Kai Tiaki NURSING NEW ZEALAND

June 2020 vol 26 no 5

Extending EN practice

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- COVID-19 surgery delays 'unnecessary'

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ISSN 1173-2032

Vol. 26 No. 5 JUNE 2020

THIS ISSUE has a focus on enrolled nurses and features profiles of ENs working in theatre, alcohol and other drug addictions and home dialysis. There's further COVID-19 coverage, with a feature on Māori nurses' mahi in Northland, another on how community mental health nurses worked to meet clients' needs during lockdown and the challenges faced by infection prevention and control nurses. There's also analysis of the mega Budget 2020.

Kai Tiaki Nursing New Zealand is the official journal of the New Zealand Nurses' Organisation, Tōpūtanga Tapuhi Kaitiaki o Aotearoa. Views expressed are not necessarily those of NZNO. *Kai Tiaki Nursing New Zealand*, under a variety of titles, has been published continuously since 1908.

Kai Tiaki Nursing New Zealand is a peer-reviewed journal. All clinical practice articles are independently reviewed by expert nurses/researchers (see below). It is indexed in the *Cumulative Index to Nursing and Allied Health Literature* and *International Nursing Index*.

Kai Tiaki is the Māori term for carer or guardian and has always been incorporated in the title of the magazine.

Practice article review process:
Clinical practice, education and research articles are critiqued for publication in *Kai Tiaki Nursing New Zealand* by nurses/educators/researchers with expertise in the subject area of the article, and by the co-editors.

This issue . . .

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Cover: With thanks to EN Karen Sword (right) and RN Emily Angus.

Cover design: Kathy Stodart.

Pre-press production: TBD Design.

Printers: Inkwise.

The value of enrolled nurses

By Mary Gordon

The World Health Organization has designated 2020 as the International Year of the Nurse and Midwife. The International Council of Nurses' theme for the year is *Nurses a Voice to Lead, Nursing the World to Health*. Never has this been more true than in the context of a worldwide pandemic.

Enrolled nurses (ENs) play a vital role across the entire health system. Here in the Canterbury health system, we have 495 ENs working across a wide variety of areas including tertiary, rehabilitation, mental health, community nursing and primary health services. We are extremely proud to have ENs as a core part of our workforce. In fact so much so, that we are the highest regional employer of ENs and employ 20 per cent of the national EN workforce.

A second-level nurse role was introduced in the late 1930s and has undergone considerable change over time. This includes its name, length of training, scope of practice, and the clinical areas ENs can work in.

Advocacy brings change

Despite all this, ENs have continued to advocate strongly for their place in the health system, lobbying the Ministry of Health and the Nursing Council. This advocacy has resulted in a number of positive changes, including bringing back an enhanced EN scope of practice, as well as ensuring a funded enrolled nurse supported into practice programme (ENSiPP).

ENs understand what their scope of practice permits under the direction and delegation of the registered nurse (RN) or other health practitioner, depending on the setting. Core to the role is an EN's ability to communicate effectively to ensure patient safety is paramount and ENs are often quick to identify a deteriorating patient. They have a strong sense of advocacy for their patients and provide holistic, thorough nursing care.

With good time management and accurate assessment and clinical skills, ENs are a valued member of our health workforce. They are adaptable and can provide sound nursing care autonomously and as part of a team.

A testament to their commitment here in Canterbury was the way several ENs volunteered to be deployed to the Rosewood Rest Home and Hospital during Canterbury District Health Board's (DHB) response to COVID-19. These ENs said of their work: *"We used our knowledge base and experience from the other areas we worked in to care for the residents".*

ENs are constantly providing support to the wider team of RNs, health-care assistants and allied health professionals. Some of our ENs are the regular staff member on a night shift. They often know the ward better than most of the team they are working with, including knowledge of the patients, policies, procedures and protocols.

Since 2011, Canterbury DHB has seen more ENs employed across inpatient services, with the majority currently employed in specialist mental health services and in rehabilitation. ENs also undertake a number of other vital roles, such as cardiopulmonary resuscitation instructors, Smokefree champions, personal protective equipment champions, and health and safety representatives.

Since 2011, their broader scope has enabled Canterbury ENs to take on additional responsibilities around both oral and intravenous medications and specialty services. We are also delighted to see a number of ENs being recognised for their work and being rewarded through the professional recognition and development programme.

ENs are passionate about their roles and the care they provide patients and their whānau. As one Canterbury EN said: *"I love my job, it can be so rewarding . . . I think about the people I help, with those little conversations or actions that made a difference in their lives, no matter how small that difference may be. But I am so glad I am able to do that."*

2020 has also seen the introduction of the ENSiPP national learning framework, to support newly-graduated ENs in their transition to practice. This framework provides a wrap-around process for new graduate ENs, coordinated through DHBs, including having them working in supportive environments and having access to adequate education and preceptorship.

It makes total sense for the health sector to recognise, value and provide opportunities to enable and develop the skills ENs bring to the table.

Canterbury DHB is looking at an integrated, whole-of-health system programme to encompass all graduate ENs who will be employed throughout the region. By continuing to grow our own, we support the continuation of these valuable regulated nurses to work in our health-care environments, further enhancing the care we deliver to the people of Canterbury and New Zealand.

It makes total sense for the health sector to recognise, value and provide opportunities to enable and develop the skills ENs bring to the table. If we can continue to do this, I see a bright future for the EN role in New Zealand. •

Mary Gordon, RN, ADN, is the executive director of nursing at Canterbury District Health Board.

Tell us what you think

'Tearing ourselves apart is counterproductive'

I AM distressed at the escalating division within our organisation. I am less concerned with the various perspectives – who said what to whom, and when – but I am very unhappy about the way members are conducting themselves.

In my discussions with colleagues, we all see a need for NZNO members to shake off their historic apathy and get involved. Our track record hardly speaks well of us – we turn out to vote in pathetic numbers, a fraction of us ever stand for roles within NZNO, and few of us engage in industrial or professional activities beyond paying fees and thinking of our indemnity insurance.

It has taken the old "allegations of bullying" chestnut to spark the most agitation and action many of us can remember seeing in the membership for many years. Irrespective of what view any of us holds on the events of recent months, it is to our combined shame we haven't been this active over other issues, like New Zealand's appalling health inequities and the lower value placed on the contribution of nurses working outside DHBs.

I highly value opinionated, committed and assertive colleagues, being one of these myself. I support the rights of people to be activists, to push for the changes they believe are needed to make improvements. However, the current level of rude, often racist, belittling and unprofessional comments on social media, from all quarters, is doing nothing to advance positive change within NZNO. Bringing the tone and level of discourse down to this low point is alienating, and dividing us from each other further.

Some of the comments I read call into question whether the authors meet the Nursing Council's "fit and proper person" test, or could be viewed as bringing the profession into disrepute. It is not an excuse to continue this behaviour because the "other side" is doing it too. Rather, we should be using any frustrations to fuel rational and constructive discussions aimed at achieving a better outcome. I hope we can all agree that our goal should be building together a vibrant, fit-for-purpose organisation that can take our profession forward. In that case, the question we all must ask ourselves is: What we can do to contribute positively to this? Tearing ourselves apart in the process is counter-productive and will not ensure a strong foundation on which to build something better.

I implore my colleagues, please temper your discussions, and elevate these back to a professional level. Keep your energy and enthusiasm, but channel this constructively – the future we all seek to build will not be achieved on keyboards. It will be achieved when we can communicate ideas, debate these calmly and professionally, and find common ground on which to agree. None of this will occur within the current environment of animosity and outrage.

It is up to each of us, as professionals and leaders, to be sensible now.

Kim Carter, RN,
Temuka

Email your letter to:

coeditors@nzno.org.nz

We reserve the right to edit letters for sense and length. Shorter letters (under 400 words) are preferred. Please include address, nursing qualifications and phone number.

SGM 'unconstitutional'

TENA KOUTOU a Memo Musa, a NZNO, a *Kai Tiaki Nursing New Zealand* ma (and others). I ask that you take action against the unconstitutional special general meeting that Grant Brookes ma are advocating to get rid of the NZNO board. It is terrible to see Kerri Nuku and the Māori and existing board members, who have been duly elected, under attack. Let the normal election process go through to replace the members who have resigned. Make a stand against cultural bullying, and follow the guidelines of the constitution.

It has been distressing and disturbing to see the nastiness flowing from professional health workers. Please combat this ongoing racist attack and wasting of members' time and finances. The cultural safety of Māori nurses and health workers is already under stress, while they are continuing to care for all members of the community, and especially Māori who suffer socio-economic health disparities. Your leadership role should be to uphold fairness and partnership, to strengthen the bicultural relationship with Māori NZNO members and to embrace the principles of the Treaty of Waitangi – partnership, protection and participation.

I have been proud of the professional and supportive way Kerri Nuku has represented NZNO in media reports on COVID-19. I have been proud of the wonderful nurses and health workers doing their jobs with aroha and manaaki for the health needs of the people.

However, within our own professional body we are weak and divided. The unconstitutional petition process that Grant Brookes ma are lobbying for is divisive and unprofessional. The focus should be on supporting and celebrating the nurses and health workers that this country and the world have come to value highly during the COVID-19 pandemic.

Let us all be kind to each other,

Kiriwai Flavell,
NorthTec third-year nursing student

April copies available

THE APRIL issue of *Kai Tiaki Nursing New Zealand*, with extensive coverage of nurses' response to the COVID-19 pandemic, could not be printed during level-4 lockdown restrictions.

However, we have printed a limited number of copies this month. If you would like a hard copy, please contact the co-editors, with your name and address, at coeditors@nzno.org.nz.

'Infighting' condemned

WITH REFERENCE to pages 7 and 8 of the May issue of *Kai Tiaki Nursing New Zealand,* can Kerri Nuku please explain the following:

- Why does she class Grant Brookes' resignation as a personal attack when some board members have clearly wanted him to leave?
- If the timing of his resignation leaves her "disgusted", why was it okay for her to add an item to the agenda regarding seeking further legal advice? Surely protecting members from COVID-19 took precedence over everything else.

The board spent about $250,000 on legal fees relating to action against Grant Brookes. That is the annual subscriptions of 452 NZNO members. How much more are they happy to spend on such legal fees?

Those who have resigned may be every bit as united as those who remain, but were simply outnumbered. A board of two divided groups is not going to function in members' best interests.

During the last district health board/NZNO multi-employer collective agreement (DHB/NZNO MECA) negotiations, I was insulted and angered by NZNO's emails recommending the offers from the DHBs be accepted. Had we followed those recommendations, we would not have gained as much as we have.

The board appears to need reminding that they are effectively the employees of the members. They are there to achieve what we request, not to give us instructions.

Should the current board members remain in their posts, they need to put as much effort into securing gender pay equity and the next MECA as they have into infighting. If they don't, they may haemorrhage members to other organisations.

Colin Woodhouse, RN,
Christchurch

NZNO kaiwhakahaere Kerri Nuku replies: I've tried to reach out to Colin and answer his questions but I've had no response. There is so much misinformation flying around, I wanted to have a good discussion with him as it's a complex issue.

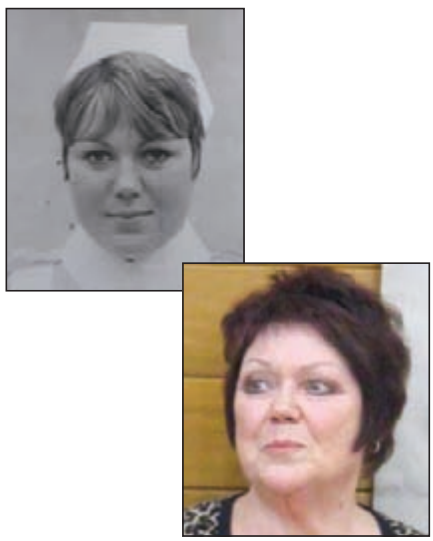
What I can say is that the current board members are very united, supporting each other and working hard in our job. We look forward to welcoming new board members joining us after the upcoming elections. We are open to talking with any members who have concerns and questions.

Tribute to mental health nurse

MY COLLEAGUES and I would like to pay tribute to a wonderful mental health nurse who recently retired after 53 years nursing.

Shona Mackintosh started as a trainee nurse at Princess Margaret Hospital in 1967 and went on to become the charge nurse at the intensive care unit at Christchurch Hospital.

In 1983, Shona retrained as a mental health nurse at Sunnyside Hospital, subsequently working across a range of services, including psychiatric services for the elderly, the psychiatric emergency service, the forensic service and the alcohol and drug service.



Since joining Te Whare Manaaki – the acute forensic inpatient unit – at its opening in 1992, Shona cemented herself as a highly valued member of the team. Her attention to detail is legendary and her support for students and new staff has been without peer, having orientated hundreds, if not thousands of them.

Shona is also well known and respected across the mental health division for her role in clinical supervision and as a founding member of the specialist mental health service at Canterbury District Health Board debriefing, also known as the critical incident stress management team. Shona's commitment to supporting staff to work through often very challenging and difficult clinical situations has been invaluable and the debriefing team would like to acknowledge and thank Shona for her work.

We wish Shona all the best for her retirement and hope she gets to enjoy her cruise one day soon.

Kate Robson, charge nurse manager
Te Whare Manaaki – Forensic Service,
Christchurch

Researcher seeks nurse leaders

NURSING IS historically and currently under-represented at high-level healthcare decision-making, policy making and organisational planning in New Zealand. The predicted loss of large numbers of senior nurses through retirement requires a targeted nurse leadership strategy to ensure an adequate supply of well-prepared future nurse leaders.

I am conducting research on the pathway into leadership for a registered nurse in Aotearoa New Zealand, for my PhD at Massey University. I have received ethics approval from the Massey University Ethics Committee. Unfortunately, due to COVID-19, my research was put on hold, but can now recommence.

I am keen to survey nurse leaders who hold New Zealand nursing registration, and a recognised leadership position in a health, academic or professional organisation. They must be responsible for the work of other nurses, or other nurses must report to them. I am also interested in surveying nurses in senior academic or policy positions who have held that position for at least three years.

If any readers meet the criteria and might be interested, I will email them an information sheet outlining the purpose of the study and establishing its legitimacy. Following confirmation of interest, a link to an electronic questionnaire will be sent. This includes a tick box to identify those participants willing to take part in follow-up interviews if required.

If you are interested in participating, contact me at dmlokerr@gmail.com or 021-2335406 after hours.

I ask previous respondents to please confirm your continued interest.

Dianne Kerr, RN, MHCare
Wanganui

Night shift age query

I WOULD like to hear from anyone who works for a district health board where their age is taken into consideration regarding working night shift, ie that you don't have to work night shift if you are a registered nurse (RN) over the age of 50.

If you are such an RN, I'd love to hear from you (email maketu_1@xtra.co.nz).

Nicky Goldsbury, RN,
Rotorua

NZNO sets up list of professional supervisors

A LIST of professional supervisors for nurses is now available from NZNO.

According to the World Health Organization, professional supervision is one of the most effective instruments to improve the competence of health workers,[1] NZNO professional nursing adviser Annette Bradley-Ingle said. It is recognised as a critical component of nursing and midwifery practice, and NZNO supports access to supervision in all areas of nursing and midwifery, at any stage of a nurse's/midwife's professional life.

Formal supervision involves regular, protected time – specifically scheduled and free from interruptions – to enable in-depth reflection on clinical and professional practice, she said.

Supervisors must be trained and competent, and in most cases it is the nurse seeking supervision who must find a suitable supervisor.

In *Kai Tiaki Nursing New Zealand*'s October 2019 edition, there was a call for trained supervisors to join an NZNO contact list. There are now 14 supervisors listed, along with their relevant education, areas of interest, region they cover, availability, cost and contact details.

NZNO will provide the list to anyone seeking supervision. It can be accessed through the NZNO Members Support Centre (0800 283 848) and will be regularly updated. New supervisors wanting to join are welcome to contact Annette.Bradley-Ingle@nzno.org.nz. •

Reference
1) World Health Organization. (2006). *The World Health Report 2006 – Working together for health. Policy briefs.* Geneva, Switzerland. Retrieved from www.who.int/whr/2006/en/

NOTICE TO MEMBERS

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

• 2020 NZNO board by-elections

Due to the resignations of Grant Brookes (president), Cheryl Hanham (vice president) and Anne Daniels, Sela Ikavuka and Katrina Hopkinson (board members), a by-election is required.

Nominations
Nominations are now being called for the following positions:
President (one vacancy)
Vice president (one vacancy)
Board members (three vacancies)

Financial NZNO members are eligible to stand. All candidates must be nominated and seconded by two financial NZNO members and be endorsed by one of the following: a regional council, te poari or a national college or section.

Any financial NZNO member who is considering submitting a nomination is encouraged to read the candidate information booklet and familiarise themselves with the code of conduct and campaigning guidelines.

The election is being conducted by electionz.com. This means that much of the election information will be sent to members by email, including sending out voting details in due course.

Key dates
The key election dates are as follows:

Nominations open: **Friday, June 19, 2020**
Nominations close: **Noon, Friday, July 17, 2020**
Voting opens: **Wednesday, August 5, 2020**
Voting closes: **Noon, Friday, September 11, 2020**

The call for nominations will also be sent to members by email, and there will be a notice on the NZNO website. Nominations must be received by the returning officer by noon on Friday, July 17, 2020.

Election
If an election is required, the board positions will be elected by a postal and online ballot of financial members between Wednesday, August 5, and Friday, September 11, 2020.

For further details, call the election helpline on free phone 0800 666 043 or contact the returning officer at iro@electionz.com.

Warwick Lampp
Returning Officer – 2020 NZNO by-election
iro@electionz.com, 0800 666 043

NZNO plans for online AGM

NZNO IS planning for an online conference and annual general meeting (AGM) this year, amid ongoing uncertainty around COVID-19 alert levels and travel restrictions.

The board endorsed the fully online option – both conference and AGM – at its April meeting.

Chief executive Memo Musa confirmed the current plan was to run conference online, over several days, but said it was possible this decision might be revisited.

An online conference would allow higher numbers of attendees and could be delivered over multiple dates rather than eight hours a day, "spreading the conference into manageable pieces", Musa told the board in his April report. This could make it more accessible to members, who might not need leave to attend, he said.

An online event was not subject to fluctuating alert levels or travel restriction and would still allow discussions, with typed questions from viewers.

It would likely cost "in the realm of $25-30,000". But considerable savings would be made from the earlier budgeted 2020/21 AGM and conference costs for the physical event. This was later provided as around $205,600.

National administrator Christine Clapcott said total estimated savings would be approximately $110,000, including travel, accommodation and operating costs, despite a loss of some $30,000 in sponsorship.

Advice would be needed on how to manage voting, and whether the one-member one-vote online system could be used, Musa said. This advice could possibly come from Electionz.com, which manages NZNO elections.

Former president Grant Brookes said at the board meeting that if the AGM wasn't held, voting results couldn't be announced or acted on until the following year.

An online event was one of five options Musa presented to the board. The other four were continuing with smaller numbers, continuing as a one-day event, cancelling or moving partially online.

Constitutional review

Draft terms of reference (ToR) for a review of the NZNO constitution, to be led by an independent person, were being drawn up by the board, with the intention they be ready for conference and AGM, Musa said.

Brookes, who resigned in May, had been working on the ToR with kaiwhakahaere Kerri Nuku. The board had agreed and signed off the bulk of work in April, Nuku said.

In his April report to the board, Brookes expressed "concern" about the lack of response and ongoing deterioration of bicultural relationships, which the board noted in October and December, he said.

"The board has previously noted, in October and December 2019, reports of 'significant strains on bicultural relationships within NZNO'. These strains are increasing in the current period," Brookes said in the report. The strains were particularly increasing in the greater Wellington region.

Brookes' reports in October and December both state that processes around October's special general meeting (SGM) "have led to significant strains on bicultural relationships within NZNO. It is expected that, for the foreseeable future, the board will need to focus actively on modelling and supporting partnership as defined in the NZNO Constitution".

Brookes also said in April that a self-assessment by NZNO and Te Rūnanga representatives at a joint Council of Trade Union Rūnanga National Affiliate Council in February was that bicultural relationships had deteriorated.

Brookes resigned shortly after the April meeting, at which a majority of board members agreed to seek legal advice over the implications of a December SGM where 66 per cent of member group representatives voted against a petition seeking a motion of confidence in Brookes. The board has held four board meetings since Brookes' resignation. Requests for minutes by *Kai Tiaki Nursing New Zealand* were turned down for reasons of confidentiality.

An independent review of events leading up to Brookes' resignation was planned, and details would be communicated to members" in due course", Nuku said. •

Reviewing measures to keep nurses safe

NZNO IS working with the Waitemata District Health Board (DHB) to implement recommendations on personal protective equipment (PPE), emergency management, planning and preparedness, and communication, acting associate professional services manager Kate Weston says.

The review follows the infection of seven nurses with COVID-19 at the DHB, following the transfer of COVID-19 patients from the St Margaret's Rest home to Waitakere Hospital. One nurse was hospitalised after becoming severely ill.

"NZNO and DHBs are working together on some high-level principles to avoid similar issues arising in the future, should we be faced with a secondary wave of COVID-19 or any other equally critical situation," Weston said.

New Zealand had been fortunate that no health workers had died from COVID-19 infections, as had occurred overseas, "but this is not to minimise the concerns that people went to work and got sick as a result of a workplace exposure to COVID-19".

NZNO would also meet WorkSafe New Zealand this month to discuss the infections, violence and aggression to health-care workers and exposure to surgical plume and other carcinogenic substances, she said. NZNO was part of a multi-union approach to these concerns. •

Chief executive rejects petition for full elections

NZNO CHIEF executive Memo Musa has rejected a petition signed by 1038 NZNO members seeking full board elections as "unconstitutional and therefore not legally valid".

In a statement on June 8, Musa said democratically elected board members cannot be removed "except in accordance with the process set out in NZNO's constitution.

"The petitions resolution does not meet these requirements and calling an SGM [special general meeting] to consider this resolution would break those rules."

Musa said he had taken "expert legal advice" including from a Queen's Counsel, who said he had "no option but to reject the resolution".

Musa said he had put "my own professional judgement and integrity on the line" with the decision.

Two petitions were lodged after the resignations of Grant Brookes as NZNO president, and four board members.

The first, signed by 1038 members including three former NZNO presidents and lodged on May 12, expressed no confidence in the six remaining directors left on the board. It called for an SGM to hold fresh elections for all 11 places.

But a counter-petition was lodged by Naomi Waipouri and Awa Love, to "reject any SGM", as members who signed the first petition "have not been fully informed".

By-election plans going ahead

Planning for August by-elections for the five vacant positions, including presidency, would continue, Musa said.

Grant Brookes resigned as president on April 23, citing ill-treatment, bullying and unethical behaviour.

Three newly-elected directors – Katrina Hopkinson, Sela Ikavuka and Anne Daniels – quit soon after, citing bullying, an "unsafe" environment and an inability to fulfil their campaign values of transparency, unity and action. Vice-president Cheryl Hanham had earlier resigned, for "personal reasons".

Memo Musa

Simon Auty, Andrew Cunningham, Margaret Hand and Anamaria Watene remain as directors, alongside kaiwhakahaere Kerri Nuku and tumu whakarae Titihuia Pakeho.

Elected by Te Rūnanga o Aotearoa members, the kaiwhakahaere has no limits on her eligibility to stand for re-election every three years. The president has a two-term limit.

Waipouri and Love's petition calls on Musa to reject any SGM or defer discussions to the next annual general meeting (AGM).

"In this instance, the 'proposed' petition seeks to remove the existing board members who have been democratically elected, without evidence or effort to manage at a lower level," the petition states. This went "to the heart" of union and professional values.

SGMs were *"expensive and time-consuming for both staff and NZNO voluntary members, delegates and representatives and should only be called when there is evidence to support claims.*

"While the ability to call an SGM must be available to members, it should not be used to undermine the principles of biculturalism, democracy and professionalism or personal advantage."

Waipouri did not respond to *Kai Tiaki Nursing New Zealand's* request for an interview.

The first petition was launched by Democracy Now, a group of members seeking to rectify the problems facing NZNO, according to former president Nano Tunnicliff, who served from 2009-2012.

Both petitions met the one per cent threshold of members' signatures. Full details are on the NZNO website. •

Membership down by 693

NZNO MEMBERSHIP has dropped by a total of 693 to 50,950 in the two months to May 31, after 1033 members resigned and 680 joined over that period.

The 693 figure included a net figure of 340 people who lost their membership after not paying fees for three months, NZNO corporate services manager David Woltman said. This movement was similar to the same time last year, when a net decrease of 570 members occurred, he said.

A third gave no reason for their resignation. Of the remainder, the main three reasons were dissatisfaction with NZNO (155), retired (124) or no longer nursing (122), member support centre lead adviser Jo Stokker said.

Students and registered nurses made up most of the resignations, at 50 and 41 per cent respectively. That compared to 47 and 36 per cent for this time last year, Woltman said.

Over 50 per cent of resignations were from district health boards; 20 per cent from primary health and nine per cent from aged care.

Stokker said calls had dropped since last month, with about 16 over the past fortnight from members not happy with NZNO and wanting to resign.

Last month, there was an increase in members leaving, after the resignation of Grant Brookes from the NZNO presidency.

Woltman said membership fluctuated regularly, particularly when DHB multi-employer collective agreements (MECA) were being negotiated, as was the case this year. "In a typical year, we would have extraordinary growth in membership during the MECA – then some people quit after the MECA is signed," Woltman said •

Surgery guidelines caused confusion

"HUNDREDS" OF surgeries were delayed unnecessarily over the COVID-19 lockdown, because of confusion over which were considered "essential", perioperative and cancer nurses say. (See also p36-37.)

Chair of the perioperative nurses' college (PNC) Juliet Asbery said the Ministry of Health (MoH) did not provide enough guidance to district health boards (DHBs) on which elective surgeries could be done, and how to protect staff.

"Protection, criteria for surgery, PPE [personal protective equipment] guidance – all those things were meant to be centralised." Instead, the ministry's PPE and surgery guidelines were "too vague, and not specific enough for practical situations", Asbery said. "They were really confusing."

At her DHB, patients likely to deteriorate within 12 weeks, causing threat to life or limb, met the criteria for essential surgeries – such as some cancer patients or those with chronically painful injuries or conditions such as neuromas. But, without national guidelines on triage for urgent care, each DHB created their own versions.

An offer from the Private Surgical Hospitals Association to perform urgent surgeries was not taken up by DHBs, despite capacity, "hence a huge backlog" that Asbery estimated at being in the "hundreds".

Cancer nurses college chair Sarah Ellery agreed more guidance had been needed, after it was left to each DHBs to decide which treatments were considered "essential", resulting in regional variations.

"It's become clear the ministry's role is overarching and supportive in many ways, but not directive in how the DHBs make decisions and operate," Ellery said. "With the benefit of hindsight, a firmer directive from the ministry may have helped."

Asbery wrote an open letter in April to the Minister of Health and Director-General of Health, calling for "collective, national guidelines" on surgeries. She warned of "significant harm" to New Zealanders from delayed care.

Patients who met criteria for treatment during normal times should receive care during a pandemic, according to the national ethics advisory committee 2007 pandemic guidelines *Getting Through Together,* Asbery wrote. "There is capacity to treat these patients in New Zealand."

An expectation that DHBs would return to "planned care" such as elective surgery only came in late April, by which point "hundreds" were likely to have been delayed, Asbery said.

Chief nursing officer Margareth Broodkoorn said the MoH's role was to provide guidance, which each DHB then translated into local policy based on the local situation.

National planning advice was also provided to all DHBs on April 21 in a memo, which set out an expectation that DHBs could plan care according to their local COVID-19 impacts and available resources, Broodkoorn wrote.

She said a "precautionary" approach was needed, given how quickly a COVID-19 outbreak could occur, but agreed it "made sense for elective work to resume" now the immediate public health threat was "contained for now".

Broodkoorn also said consistent PPE guidelines were available on its website. •

NZNO seeks pandemic planning inquiry

NZNO WANTS an inquiry into the health system's pandemic planning and preparedness, after a survey of members' experiences with personal protective equipment (PPE) found "clear systemic failings".

NZNO principal researcher Jinny Willis, in partnership with private "think tank" the McGuinness Institute, surveyed 589 NZNO members from late April to early May about PPE.

Researchers found that supply of PPE was a common problem across all district health boards (DHBs), and there was a lack of preparedness and confusion over what DHB responsibilities were on PPE. *"The NZNO survey makes it clear that for many frontline respondents, something went badly wrong,"* the survey said.

An inquiry was needed, focusing on whether the Ministry of Health (MoH) failed to mobilise masks and other PPE, whether the stock was not there, or a combination of both, the researchers said.

"It is unclear, even today, who failed and how they failed. However, what is clear is that PPE stock did not reach all home-based care, disability-care facilities, aged-care facilities, primary health-care providers, hospices, GPs, Māori and iwi health-care providers and many others. The problem needs to be identified so that it can be resolved. The very people who were put on the frontline without the recommended PPE deserve an honest answer and a clear solution, otherwise the same mistakes may happen again," the survey report said.

Willis said the survey suggested staff in intensive care and theatre generally felt supported in their PPE use, but not so much in the community. "My sense is most of the preparation had taken place within the hospitals, rather than in community or primary care, which is where most cases were going to be encountered."

The research also suggested there had been challenges "translating the messages" around PPE from the MoH, through DHBs "to the grass roots". Understaffing also contributed, as some respondents were unable to find time or cover to change their "saturated" masks, Willis said.

NZNO kaiwhakahaere Kerri Nuku said she hoped NZNO would be involved in any inquiry, after an "incredibly unprepared" health system was revealed by members. She hoped their experiences would improve preparations for future pandemics. •

DHB nurses seek 17 per cent rise

A 17 PER cent across-the-board pay rise over two years is NZNO's starting point in district health board multi-employer collective agreement negotiations (DHB MECA), which kick off on June 23. NZNO lead advocate David Wait said the increase – 10 per cent immediately and seven per cent in the second year – was necessary to attract and retain nurses in the workforce.

"New Zealand has the highest proportion of internationally qualified nurses [IQNs] – at 27 per cent – in the OECD [Organisation of Economic Co-operation and Development]. We have an over reliance on IQNs and we need to make the job attractive enough to train and retain our own workforce," he said.

Wait acknowledged the negotiations were taking place as the post-COVID-19 recession was biting and unemployment rates were soaring. "But there is commentary the recession is not going to be as bad as predicted. We certainly hope that is the case. And it is important to remember nurses will be essential in any future waves of COVID-19."

In a reversal of the usual situation, he pointed out healthcare assistants (HCAs) on the top pay step in residential aged care now earned 10 per cent more than the base rate for DHB HCAs. The top HCA step in aged care was $25.50 an hour, while the top step for DHB HCAs was $23.12/hr. To bridge this pay gap had implications throughout the DHB nursing workforce.

During the pandemic there had been a lot of rhetoric about the value of nurses in the battle against COVID-19. "That rhetoric needs to become reality and nurses need to be paid commensurate with their contribution," he said. "That means a substantial pay increase."

Other important claims were for more sick leave and better access to it. The COVID-19 admonition to "stay home if you're sick" was admirable but meant more sick leave was "absolutely necessary" so nurses could protect themselves, their patients and their communities, Wait said.

More and better professional development for all nurses, along with the time to undertake it, was another major claim.

The recommendations of the Ross Wilson report had largely been completed, Wait said. "Members can see there are twice as many delegates [12] on the negotiating team as last time. They can see there is a professional nursing adviser on the team [Julia Anderson]. Members know the claims and we've been able to spend the money needed to make things happen."

Acting industrial services manager Glenda Alexander will play an advisory and supporting role during the negotiations. She will not be a part of the negotiating team, but her knowledge and experience of the MECA would be invaluable, Wait said. "She coordinated and was a lead in the formation of the first MECA and led three subsequent negotiations. It will be comforting to have her knowledge and expertise to draw on."

NZNO's team will have a training day on June 22 and then go into three days of negotiations. The DHB team will be led by long-time lead negotiator Kevin McFadgen. •

Pay parity needed to stem 'exodus'

THE GENERAL Practice Leaders' Forum (GPLF) etimates a $15 million funding boost is needed to achieve pay parity for primary health care (PHC) nurses. And its chair Kate Baddock is "very concerned" about the impact on recruitment and retention if pay parity is not achieved.

Those concerns are echoed by NZNO PHC national delegate Denise Moore, who predicts a "mass exodus"of nurses from the sector if the current 10.6 per cent pay gap between senior nurses in the sector and those working for district health boards (DHBs) is not bridged. "We have the same qualification. PHC nurses have high capability. We keep people out of hospital. We were on the COVID-19 frontline, out swabbing people. Why is there this pay disparity? It shouldn't be there. When I started working in PHC 11 years ago, I was paid $1.15 an hour more than my DHB colleagues. Now I'm paid 10.6 per cent less." Moore, who is also on the PHC multi-employer collective agreement (PHC MECA) negotiating team, is a senior nurse at a 24-hour accident and medical clinic in Christchurch.

Baddock said the GPLF had continued to push for improved funding for general practice, both for sustainability generally and to close the pay gap. "This has been part of the current dialogue with DHBs and the Ministry of Health regarding capitation rates. We are confident all the parties acknowledge the need to close the gap. However, there is no certainty of available funding at this stage,"she said.

PHC nurses 'furious'

Moore said PHC nurses were furious at the situation and would fight for pay parity. NZNO lead advocate Chris Wilson said the situation was "difficult, disappointing and frustrating" for members, who last month rejected a 4.5 per cent offer over two years. "PHC nurses have contributed to stemming COVID-19 and in battling the measles epidemic and yet there's not the same value placed on them [as on DHB nurses] in terms of remuneration," Wilson said.

And she strongly challenged Health Minister David Clark's claim the Government could not interfere in the nurses' pay claim because PHC nurses were employed by private employers. "What we saw post-Budget was additional funding for privately-owned early childhood centres because of their significant recruitment and retention issues before COVID-19. They, quite rightly, got more money to pay their employees more. The Government can do the same to fix the situation we are in."

She pointed out that an NZNO survey of PHC nurses late last year revealed 70 per cent were considering leaving because of higher pay elsewhere. And Wilson referred to the "unique situation" of NZNO members and employers both supporting pay parity and the need for more funding to achieve it.

A petition calling on the Government to intervene and that DHBs provide the money needed to remedy the pay gap had attracted close to 8000 signatures at press time. It is "fully supported" by the GPLF, which has sent it to its members. •

National group adopts bicultural leadership

AS WELL as changing its name, the National Nursing Leaders (NNL) group, representing major nursing organisations, has adopted a bicultural leadership model.

Lorraine Hetaraka-Stevens, Ngāti Kahu, Ngāti Ranginui, Te Arawa, and a board member of the College of Nurses Aotearoa, has been appointed co-leader, alongside College of Nurses executive director Jenny Carryer.

Carryer said the new name was "less confusing", better reflecting its purpose. Having both a Māori and non-Māori chair ensured "equality of process".

A new Pacific nurse representative, 'Eseta Finau, had also joined this year.

The group seeks consensus on current issues from a nursing perspective, across sectors, and advises the Ministry of Health.

New terms of reference were due to be signed off at a meeting in early June, where members would also be discussing the key strategic direction for nursing in a post-pandemic future, Carryer said.

The group also hoped to hold an education summit towards the end of the year, to discuss how to grow the nursing workforce, particularly Māori, Carryer said. "Many structures and practices have been the same for 20 years, so need a change," she said, noting that in 2019, for the first time in a decade, the number of internationally-qualified nurses registering exceeded the number of locally-trained nurses.

Attracting more Māori into nursing would be a "core" part of that conversation, said Carryer, who acknowledged the work had been ongoing for years. "It's not that the NNL doesn't care passionately about the Māori workforce, but in health, nothing moves fast."

Hetaraka-Stevens could not be contacted for comment.

The NNL hopes to double the number of Māori nurses from seven to 16 per cent, to match the Māori population, by 2028.

A Māori caucus within the group was established in 2017 to bring a Māori-led approach. Its members include chief nursing officer Margareth Broodkoorn, NZNO kaiwhakahaere Kerri Nuku, Te Ao Māramatanga New Zealand College of Mental Health Nurses kaiwhakahaere Chrissie Kake and the National Council of Maori Nurses Kahungunu representative Donna Foxall. •

Free training for aged-care workers

FREE TRAINING for aged-care workers will bring in badly needed workers for an under-funded sector.

Early this month, the Government announced more details about free training for a raft of workers for the next two and a half years under its trades training scheme, originally announced in Budget 2020.

NZNO industrial adviser Lesley Harry welcomed the funding which, she said, would aid the recruitment of aged-care workers. "Caring for the elderly needs to be made more attractive as an option for job seekers. This occupation is considered the poor cousin in the health sector, yet the needs are so great, as we have seen during the COVID-19 pandemic. There is a grave shortage of people being attracted into the sector and who want to stay. Although providers are required to provide training, there is no incentive to fund this training."

What was needed was a skilled and qualified aged-care workforce, she said, as the people being cared for were usually very frail, with multiple co-morbidities. Greater incentives were also required to attract new graduate nurses to the sector. Younger nurses tended to avoid aged care, seeking higher pay rates and better conditions elsewhere.

Harry also stressed that training and qualifications were only one part of the equation. "The regulations governing the sector are also woefully outdated," she said. "A whole-system approach to much needed change across the board is what NZNO is seeking." •

Period poverty addressed

NZNO WOMEN's Health College (WHC) is "thrilled" the Government is finally investing in ending period poverty for young wāhine in New Zealand, chair Denise Braid says.

Prime Minister Jacinda Ardern – who is also minister for child poverty reduction – and Minister for Women Julie Anne Genter announced early this month a $2.6 million investment in free period products for school girls beginning next term.

The WHC has supported University of Otago researcher Sarah Donovan, who last year applied to Pharmac to fund menstrual products in lower decile schools, but was turned down.

"Period poverty" was a huge barrier for young women to achieve both educationally and socially and was one of the far-reaching effects of poverty, Braid said. "This is a huge win – Sarah's persistence has certainly paid off."

Donovan said that after four years lobbying, she was "elated" at Ardern's decision. "It's just so progressive. She seems to have a real interest in child poverty."

"When I did the Pharmac application [for funded period products], I knew it was unlikely to succeed but hoped it would create a debate on the issue. So the end goal, I feel, has been reached."

She planned to continue her focus on destigmatising the conversation about periods in schools, as well as ensuring disposal bins were readily available. "It's not over yet."

WHC would also like to see GST removed from all sanitary supplies for period and urinary incontinence, Braid said. "This would be an excellent next step."

The period products initiative will begin in 15 Waikato schools in term three, expanding to all state and state-integrated schools on an opt-in basis over 2021. •

Protection from violence

NURSES SHOULD now get more protection from violence at work, under a proposed new law.

As reported in Stuff last month, a NZ First member's bill introducing a six-month minimum sentence for assaults on first responders such as paramedics, police, firefighters, and corrections officers, was sharply criticised for not including nurses, midwives and other health-care workers.

The party has now said an amendment to the Protection for First Responders Bill would be tabled to add emergency department health-care workers to the legislation.

This follows 76 submissions made during the recent Justice Select Committee hearings, which led to consultation with the sector. A second reading of the bill is expected later this month.

In a submission to the committee in March, NZNO said failure to include nurses, midwives, health-care workers and kai mahi hauora in the Bill would only serve to further institutionalise the abuse nursing staff faced on a daily basis.

NZNO professional nursing adviser Suzanne Rolls said NZNO had been strongly advocating for the amendment, which was a significant step in ensuring nurses had safe workplaces.

"This is such an important step — we really needed the legislation, but we want more to be done to address the problem." Nurses wanted "the triggers of violence to be removed and the provision of increased security", she said.

She also called on WorkSafe to do more than just provide guidelines to district health boards (DHBs). "We would like them to do actual inspections."

In its 2019 membership survey, 10 per cent of NZNO members indicated that, during the last year, they had been either physically assaulted, verbally abused and/or subject to sexual innuendo, abuse or threats. The highest rates of abuse occurred in emergency departments or in mental health or aged-care settings.

College of emergency nursing chair Sandra Richardson said, in her submission, that verbal abuse, physical assault and sexual innuendo or threats by either patients or accompanying persons was commonplace for nurses.

"Instances of reported violence tend to get swept under the carpet and nurses often don't bother with them. That means levels of violence are likely higher than what records might suggest."

Richardson said Accident Compensation Corporation information showed assaults on DHB nurses were the third-highest cause of ACC claims by nurses and that physical injuries from assaults made up 14 per cent of all DHB nurses claims. •

New fast-track nursing degree

MASSEY UNIVERSITY has announced a new postgraduate degree aimed at people wanting a career change to nursing. This will allow students with any undergraduate degree to become a registered nurse within two years. No previous health degree or experience is required.

The master of clinical practice (nursing) is available from semester 2. The course will be predominantly delivered online, with some block courses and clinical placements.

According to programme director Rhonda McKelvie, students will study theory related to health, nursing knowledge and science using online approaches that support people to learn when it suits them. In addition, simulation in labs will be coupled with high-quality clinical placements in hospitals and community settings.

With only eight per cent of New Zealand's 54,460 practising nurses identifying as Māori and four per cent as Pacific, the new degree would have a strong focus on building health and social equity, Mckelvie said.

Applications for the new degree closed earlier this month. •

Nurses honoured

TWO MENTAL health nurses have been named Officers of the New Zealand Order of Merit in this month's Queen's Birthday Honours.

One is regular contributor to *Kai Tiaki Nursing New Zealand* Anthony O'Brien, who, according to his citation, has had a career in mental health nursing for 46 years. An educator, researcher and writer, O'Brien has made a significant contribution to the development of mental health nursing as an evidence-based profession. He is a clinical practitioner who was also a lecturer and senior lecturer at the University of Auckland between 1997 and 2019 and is currently associate professor of mental health nursing at the University of Waikato. He was the inaugural president of Te Ao Māramatanga – New Zealand College of Mental Health Nurses and has continued to support the organisation for the past 17 years. O'Brien is now a member of the community liaison group that the police consult with over the use of force and other issues.

The second is Daryle Anne Deering of Christchurch who spearheaded the development of addiction nursing in New Zealand. Her career in mental health and addiction nursing spans close to 50 years.

In 2007, she completed her PhD, studying methadone treatment in New Zealand. She was a founding faculty member of the National Addiction Centre at the University of Otago, where she was a strong voice for effective provision of methadone maintenance treatment. She was the director of mental health nursing for the Canterbury District Health Board from 2000 to 2007 and served as president of Te Ao Māramatanga from 2010 to 2014. She led a national nursing reference group that eventually developed the New Zealand Addiction Specialty Nursing Competency Framework in 2012, which continues to guide mental health, primary care, and addiction nurses in their professional development.

A number of other nurses also received honours. The full list is available at https://dpmc.govt.nz/publications/queens-birthday-honours-list-2020 •

Iwi response to COVID-19 shows

Te Tai Tokerau Māori health advocate Moe Milne, Ngāti Hine and Ngāpuhi, says Māori have proven they can take care of their own whānau, after a nurse-led response to COVID-19 reached hundreds in vulnerable Northland communities.

I think what really struck me is the amount of work Māori nurses do – the providers and the nurses. They initially saw that the information, vaccination and assessments weren't getting out to the community – people weren't turning up to the official testing stations, so they took matters into their own hands.

It was the leadership of our Māori nurses, and some places were really fortunate to have Māori doctors as well.

Nobody has any idea what it meant for Māori nurses – it doesn't end there, on the frontline. Nurses get out to the marae, they do the vaccines and swabs, then they're getting in their gumboots and in their trucks to help deliver care packs to whānau in rural areas. Then they put their high heels on and deliver meals to our kuia and kaumātua.

Our Māori nurses and midwives are the backbone of Māori providers. These are people who really care about their community – which is primarily kuia and kaumātua and other vulnerable groups.

The number of people affected by COVID up here has been very small. It could have been so much worse. We have high poverty, a high Māori population, all those things, but we said: *"We've got this, we've got to take care of our people."*

Māori providers across Te Tai Tokerau joined forces, and they were involved in making sure we were taking care of our whānau and hapū.

Our iwi – Ngāpuhi, Ngāti Wai, Ngāti Hine and the hapū of Whangārei – we all agreed to work together and made sure our older people got care packs, with sanitiser, face masks, and things like that. They had food too, but our kaumātua said "Keep the groceries, for the needy families". So we started delivering home-cooked meals to them instead, which could be frozen.

It doesn't matter where you look, lots of people up here are vulnerable. We take care of everybody here, not just the older people. Everybody came to get vaccinations for the 'flu – we made them freely available to everyone – and thought that will lessen the impact of winter. So people turned up and got vaccinated and had a COVID-19 test, too.

Providers were ringing people and checking on them. In the Far North district, they made some 'kia ora calls', and that grew into a community mental health support group.

At my marae, Matawaia, when they knew about the clinics, people told each other. At Ngāti Hine Haoura Health Trust, when they knew about the clinics, people told each other – families rang each other up, said "come on down".

The main motivating factor was that nobody wanted the responsibility of passing on the disease to someone else. We felt a strong responsibility, as a whānau.

The second thing was we felt we were in this together – parents, elderly, young people, children – we are all vulnerable, so have to take care of each other.

And the other thing is that people came because they knew there would be a Māori nurse or doctor. Māori, first of all, are more likely to have the same experience, they come from whakapapa. They are more likely to understand your experience, and be far less judgemental than other people. It is trust. It showed we can take care of ourselves.

But in the first week of going into level two, the Government put out legislation restricting tangi – with no consultation with us, nothing.

Māori mental health advocate and nurse Moe Milne.

Nurses get out to the marae, they do the vaccines and swabs, then they're getting in their gumboots and in their trucks to help deliver care packs to whānau in rural areas.

An affront to Māori

We have a vested interest in managing this, we are not going to go to tangi. The threat was made that if we don't obey, we will be invaded by police, with no warrant. For many people here, their background means that already happens, without that legislation. That caused a real furore, it was an affront to Māori, saying "you can't take care of yourself".

We've had two large tangi since then, for important people. Everybody went and maintained their distance, it was fine.

I am not that hopeful that a Māori

power of Māori-led health care

approach would be given freely – I think we are going to have to battle for it. We are all prepared to do that.

We are not going back to "normal" as that normal was not very good for Māori. Our way is manaatikanga, looking after each other. We have shown that is good for everybody.

The difference is the care for vulnerable people from those who have had the experience of being Māori.

Why can't we have this ordinarily? We are very capable of taking care of our own people. If we have the support, we get on with it.

Māori nurses all did amazing work, they had to deal with their own challenges, with their own whānau. But they were willing to go out and they kept going out." •

PHOTO: MATT KING

Te Rūnanga o Taumārere ki Rākaumangamanga — an iwi group which covers Waikare, Te Rawhiti and Kororāreka in the eastern Bay of Islands — delivered 120 kai packs to vulnerable families in the area, assisted by Northland MP Matt King.

Māori make 'better decisions' for Māori

Record levels of Māori in Northland received 'flu vaccinations and COVID-19 tests, in an iwi-led response that reached the "remotest corners" of Te Tai Tokerau, an iwi health provider leader said.

"The challenge now is to hold onto this high-trust, flexible approach," Ngāti Hine Health Trust (NHHT) chief executive Geoff Milner said. "When you allow Māori to make their own decisions, you get better results, rather than boxing us into contracts."

About 10 Māori health providers worked around the clock during lockdown, taking community testing centres as well as mobile testing and 'flu vaccination stations into the "remotest corners" of Tai Tokerau, Milner said.

"These efforts contributed to one of the highest testing rates for Māori in a district health board (DHB) rohe and the largest number of Māori receiving the 'flu vaccination for a very, very long time, and this mahi continues."

Regional DHB statistics show that by mid-May, 78 per cent of nearly 9000 COVID-19 tests in the region had been done at community or mobile clinics, many run by Māori health providers, also offering immunisations. "More Māori were vaccinated in those four weeks (mid April to mid May) than in the whole of 2019."

In the NHHT region of the mid-North alone, Milner said of 360 people tested, 56 per cent were Māori. Of 329 vaccinated for 'flu, 74 per cent were Māori and 25 per cent were children – some of whom also had their vaccinations updated.

After Te Kahu o Taonui, the organisation for Te Tai Tokerau iwi chairs – got in touch with the Ministry of Health early on, the Government quickly made its contracts flexible, allowing Māori hauora, social and housing services to quickly shift resources and people to where they were needed, in a "high-trust" environment.

Māori wanted flexible, mobile health services, he said. "We were out there, we didn't send our staff home, we didn't do virtual consults – it was done with our shoulder to the wheel, by Māori health providers, as mainstream practices had their doors closed."

Nurses were the "stars" of the COVID-19 response, he added. "They were the leaders and our role was to put the support around them. They were the ones driving up the shingle roads, or pitching the marquees on the side of the road. Their efforts were so appreciated." •

Report by co-editor Mary Longmore

PHOTO: *THE NORTHERN ADVOCATE*

Te Hau Ora o Ngāpuhi nurse Rhonda Zielinski at Kaikohe's drive-through community-based assessment centre last month.

Caring for vulnerable mental hea

Caring for vulnerable mental health patients during the level-4 lockdown restrictions posed many challenges. Nurses had to adapt their way of working to ensure clients got the care they needed.

By Justine Dahlenburg and Cath Allwood

The crisis nurse role within a community mental health team (CMHT) is varied. It includes a number of functions: duly authorised officer, case management, crisis assessments, support for colleagues managing a client in crisis, providing leadership and clinical knowledge to all members of the multidisciplinary team (MDT), role modelling, and being available for peer supervision and liaison with wider community agencies.

It's a busy job on an average day, with the crisis nurse often working alone, and making clinical decisions in complex situations. Our south community mental health team at Southern District Health Board consists of 29 clinicians across the MDT, managing a caseload of around 550 clients.

As the COVID-19 pandemic was unfolding globally, New Zealand felt reasonably safe and unaffected by this new, invisible threat. Then, on March 23 (Otago Anniversary Day), the Government announced the four-stage alert system. This announcement gave our team just 48 hours to prepare for delivering our services under level-4 restrictions.

The entire team sprang into appropriate physically-distanced action – not that easy in the confines of the allotted office space. We identified those on our caseloads considered to be most vulnerable. Planning meetings took place at all levels, from the operational leadership team through to individual teams. We were given the directive to see people face-to-face if absolutely necessary.

Service changed in 48 hours

One by one, our colleagues collected what they needed to work as effectively as possible from home for the next four weeks. Within 48 short hours, we stopped being a fully mobile service and were faced with the reality of what our service was now going to be like for both staff and clients.

Foremost on most minds was getting access to, and setting up technology from home so we could manage our caseloads. Staff access to technology varied, as did their savviness in setting it up and using it; some had full remote access, others had limited access. There were issues around cellphone and internet coverage. Our new normal quickly morphed into days in front of our computers, phones stuck to our ears, MDT meetings via phone or Zoom. Email correspondence spiked. Phones ran hot.

Essential face-to-face contact

Our team decided essential face-to-face contact for our clients would be delivered by our crisis nurses. Triage would continue with our triage nurse. This nurse would also check the office answerphone daily, review information about clients who had contacted the 24-hour crisis team and advise the crisis nurses and case managers/medical team, who then decided what follow-up was needed.

The crisis nurses became a team within a team – two bubbles of two, who would come into work as required to ensure our service still operated. I have had a joint case manager/crisis nurse role on the team for 19 years.

Our work included co-ordination of depot injections, welfare checks to those uncontactable by phone, crisis assessments, Mental Health Act assessments, reviews or other requirements such as court reviews.

In addition to home visits during the week, each of the crisis nurses had a caseload, which meant managing their time to enable contact with these clients by phone. They also had to attend the twice-weekly MDT teleconferences, the weekly crisis/triage teleconferences and be available to support colleagues who needed additional help with some of their clients.

Our first day out of level-4 restrictions saw us trying to work out what we needed to take with us on our home visits – medications and charts, equipment such as syringes, sharps containers, address and phone lists, personal protective equipment (PPE), hand sanitiser. This was a day of trial and error – our next venture would be much more streamlined! So, what had we forgotten? Well, lunch for one thing and nowhere handy to buy any and no time to queue outside a supermarket. Our drive across the deserted streets took us from one side of Dunedin to the other without incident. The city had an eerie feeling to it.

The majority of people we visited were happy for us to enter their bubble to administer injections and conduct assessments. One or two people appeared unaware of level-4 restrictions. Some people were a little shocked opening the door to see us standing in full PPE gear, others had been prepared when we had phoned to do a COVID-19 screen. Not everyone had a phone or answered it, which added to the challenge of locating some clients and preparing them.

We felt fortunate we had our work bubbles in which we could talk. This helped us contain our anxieties and allowed us to remain calm and reassuring to our clients and families.

As we explained the situation to clients and how we would be working over the next few weeks, the reality of the circumstances in which some of them lived became more starkly apparent. Social isolation and, for some, social deprivation as well, was something that really struck us. We gave clients injections in their gardens or on their front porches

lth patients in level-4 lockdown

The Southern DHB's south community mental health team crisis nurses, who formed two work bubbles during the level-4 lockdown, are, from left: Kate Glover, Marina Anderson, Cath Allwood and Justine Dahlenburg. Their experience as crisis nurses ranged from 18 months to more than 20 years.

to avoid breaking someone's bubble; for some, privacy was no longer a priority. We provided reassurance and education on precautions to help them stay safe and well and information on how to access supports, eg grocery deliveries.

More resilience in level 4

We did not witness any increase in distress among our clients during level 4; rather people seemed to be more resilient. There was no increase in referrals, crisis work or crisis assessments during level 4, compared to before level 4. But the true impact of the lockdown on our clients won't be known for some time.

When we returned to the office at the end of a long day, we then had to ensure all relevant documentation was completed and all relevant information communicated with the wider team. We would finish off the day ensuring equipment, medication and scripts had been organised for the next day out. We spent a lot of time on our cellphones, communicating with staff, locating clients, liaising with services and support agencies. We relied heavily on technology.

The lockdown meant our work environment had altered dramatically within days. Usually, our community visits would be anonymous – we would be in mufti. Now, we were wearing PPE gear for each person we visited. This gear was put on in public, standing at the boot of our vehicle. We fielded questions from members of the public about what we were doing – some wanted reassurance, some were oblivious to what was happening, some gave us a wide berth. Our attire in near-deserted streets did draw attention. We were aware this also drew attention to the people we were visiting.

Within a few weeks, we were dab hands at preparing our equipment, packing the car, donning PPE gear, and cleaning the car and ourselves at the end of each day. Hand sanitiser seemed to quickly dry and age our skin. We also were mindful of our environment every time we used PPE and single-use plastic items that we knew would be heading to landfill.

Loved ones would watch us arrive home and wait till we had showered. In the first few weeks, the drive home after work was a time of reflection and a reminder of how much our worlds had changed. We each had our own anxieties about the virus, our personal safety, and the safety of loved ones, clients and colleagues. We felt fortunate we had our work bubbles in which we could talk. This helped us contain our anxieties and allowed us to remain calm and reassuring to our clients and families. We were thankful to have job security. Each one of us was resolute that our work needed to continue and each week we had to adjust how we achieved this. We found ourselves being creative and adaptive and we continually assessed what was the best way to deliver face-to-face services during these unprecedented times.

Nurses have been at the frontline of this pandemic and have had many experiences and insights into what the future of nursing practice might look like. As we look towards the future and contemplate what lies ahead, these lessons will be significant and valuable in informing new ways of working. •

Justine Dahlenburg, RN, PGDip (mental health nursing), is a case manager/crisis nurse with the south community mental health team, Southern District Health Board (SDHB).
Cath Allwood, RN, BN, is a crisis nurse with the south community mental health team, SDHB.

Truths and myths about PPE

Protecting health-care workers during a pandemic is not just about PPE supplies. It is far more important to develop a whole-health-system approach, one IPC nurse argues.

By Carolyn Clissold

A month ago people asked me how I, as an infection prevention and control (IPC) nurse, was doing in the midst of a pandemic. I was many things – exhausted, frightened, anxious, but also frustrated.

IPC nurses at that time were trying to be the glue that held systems together. And that was difficult. We were dealing with patients with COVID-19, changing our practice, facing difficulties with supplies and the rise of media IPC experts. We read media commentary focused on personal protective equipment (PPE), while other elements of IPC practice seemed to have been missed.

I want to expand our discussion from PPE itself to some basic IPC principles, focus on different and challenging models of care in pandemics, and talk about lessons from IPC systems that will protect nurses in the future.

At the end of January, I was on holiday and heard from friends that the coronavirus emerging in Wuhan was transmitting between people – easily. I felt sick. I knew this could be big. The saving grace with the previous coronavirus – MERS-CoV – was that, although lethal to humans, it had never been very successful at moving between human hosts.

'We knew the drill'

Back at work we checked on our N95 respirator order. Too late. We were already on back order and must wait in line. Given the prevailing "just in time" ordering model that promotes small inventories to protect against wastage, we would be cutting it fine. Those of us who have dealt with previous outbreaks (SARS, Ebola, H1N1 influenza) know the drill: expect shortages in PPE worldwide, be in quick, prioritise.

I had this reinforced previously when I attended a meeting where a major international mask supplier talked about pandemic modelling. I took away two valuable lessons. Firstly, in pandemics, shortages will occur. This is to be expected, and in spite of best efforts. Secondly, rationing will occur.

Clinical nurse specialist Carolyn Clissold

The speaker proposed that nurses would be issued with two masks for their shifts, and that would be all. I was horrified. But this is now the new normal overseas. Major shortages of PPE force care staff to put on their PPE at the start of their shift and remove it at the end. Some nurses are issued with seven N95 respirators, which they save at home, reusing the same one seven to nine days later, when the virus has died. This is in sharp contrast to the droplet precautions model we teach – a nurse puts on a mask, sees one patient, does the care, and removes the mask when they leave (with hand hygiene of course). They may go in many times during their shift, using many masks. This single-use model has been the predominate, transmission-based precaution care model.

Fast forward to March 2020, when there was extensive media commentary around COVID-19, much of which focused almost exclusively on PPE. This narrow focus was understandable. Our overseas counterparts were grappling with scenes and conditions that were terrifying and it was natural to think that unlimited access to high quality PPE was a priority. Lost in the debate was the fact that in a pandemic, there are never unlimited supplies and it's impossible to know when a pandemic will end. Health-care workers need to be kept safe as a priority, but by a range of measures.

The media messaging in New Zealand was also providing conflicting advice. At times, PPE was changed too infrequently,[1] then too often.[2] Shoe covers and hair nets were vital,[3] and then were too elaborate and increased risk.[4] PPE was needed for all "frontline" health-care workers,[5] but what "the frontline" actually meant was never defined. Given these statements, it is understandable nurses were confused and afraid. All of these statements fed fear that things were wrong. Few statements were written by anyone with IPC training.

IPC practitioners teach standard precautions. These are the core principles designed to keep us safe from infection in health care. Standard precaution models have changed over time, evolving to include blood and body fluid (formerly universal precautions[11]) and protection from blood-borne virus risk. It changed again with the initial SARS outbreak in 2003 to include cough etiquette and source control (advising the person with symptoms to wear a mask). The World Health Organization standard precautions model starts with an assessment step –

are you at risk from infection?[7] This step also applies in COVID-19 risk mitigation. *Are you well? Have you travelled? Am I at risk from you? Are you at risk from me?* This risk mitigation has become embedded in our redesigned health processes. It implies that if the answer is "yes", then management has a responsibility to mitigate risk by distancing, delaying appointments and adding other barriers. And supplying PPE.

Bald statements that all health-care workers need PPE overlook this critical assessment step. The comprehensive PPE survey commissioned by NZNO asked only if PPE was available. It did not ask whether nurses were at risk in their workplace from COVID-19, and what other mitigations steps were taken. If only an IPC nurse had been consulted!

Advice from the United Kingdom now includes the extended use mask model, and calls this "sessional use".[9] You keep the mask on for multiple patient interactions, as you are either looking after many COVID-19 patients, the community prevalence is high, or you don't know if you have COVID-19 yourself! High community prevalence never eventuated here, so we never had to move to this model for health-care workers. Our low community transmission rate showed us this.

Extended use situations did occur, though, eg in community COVID-19 testing clinics and in COVID-19 outbreaks in aged care. New procedures need to support this model, eg the continued emphasis on hand hygiene between patients and the impact of long sessions in PPE.

Sector experts not heard

Earlier this year, I wrote to leaders at NZNO, concerned that expert IPC voices were not being heard or represented by NZNO. I recommended, on behalf of NZNO's IPC nurses' college, that IPC recommendations should come from sector experts. I understand NZNO was committed to supporting and responding to the many voices worried about supply of PPE. However, I would still caution NZNO to be part of the solution and not add to the problem of media sensationalising.

One of the difficulties when reviewing the cases where nurses have been infected by COVID-19 is that the reviewers did not use a comprehensive and agreed COVID-19 care standard against which to review care. So reports can highlight concerns of the reviewer and miss commonalities between cases that would shed further light on prevention.

For example, why does dementia care seem riskier? Reviewers easily find the PPE poster on the Ministry of Health (MoH) website,[10] but may not have reviewed care against the MoH infection, prevention and control guidance document.[8] Reviewers may miss the "art of IPC", including the sequencing of activities, minimising of activities that may create aerosols, the support structures that are needed outside the COVID-19 area, whether staff did increased cleaning, communication, staffing levels and sluice room availability. Lastly, is review of an event more effective if the lessons become media headlines, or if district health board participants can really practise open disclosure that promotes learning?

Tough PPE choices

I thank utterly those nurses who have fronted up to the realities of nursing patients with COVID-19. You should all have our best PPE. I also want to thank those senior nurses, nurse specialists, nurse managers and others who had to make tough choices about PPE, and have changed advice as evidence, or supply changed, sometimes in a few hours. This was leadership. Putting in processes that protected health-care workers beyond PPE took a whole-health-system approach. This whole-system approach transformed our delivery models of health care, to ensure greater worker and patient safety. Team work made this possible.

Learning from experience

We are now entering a period where we can reflect on decisions that were made. It is tempting to blame those who made such decisions, especially during the height of our outbreak curve. I want no part of this. Every decision over the last few months has been based on the evidence and resources available at the time. We obviously want to learn from experiences and fine-tune our recommendations accordingly. This can only happen if people feel free to talk and collectively share their experiences; and courageously make new recommendations for an improved system. The IPC community can help steer the implementation of evidence at all levels of pandemic planning and care. They bring a perspective that has been missing from the national debate.

We can all be proud of the New Zealand response to COVID-19. IPC teams and IPC nurses around the country have provided leadership and guidance through these difficult times. Let's continue to work together for better health outcomes for all. •

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The evolving EN role

As the enrolled nursing role has continued to evolve over the past 40 or so years, ENs are finding new areas in which to practise. One of these is perioperative care.

By Lorna Adrianne Davies and Juliet Asbery

The scope, education and practice of the enrolled nurse (EN) in New Zealand has evolved significantly since its inception under the Nurses Act of 1977, its subsequent demise in 1993, and its resurrection in 2002.[1]

When EN training restarted in 2002, a new scope of practice was developed. This stated that ENs work with people *"with predictable health outcomes in situations that do not call for complex nursing judgement"*.[2] However, over the following decade of much debacle and discussion regarding the second-level nurse's role, further advancements to the scope were eventually made. In 2010, the existing EN scope of practice was published, and the aforementioned statement was omitted. The current EN scope of practice states that ENs practise:

"under the direction and delegation of a registered nurse or nurse practitioner . . . in community, residential or hospital settings . . . contribute to nursing assessments, care planning, implementation and evaluation of care for health consumers and/or families/whanau. . . In acute settings, enrolled nurses must work in a team with a registered nurse who is responsible for directing and delegating nursing interventions. . . In some settings, enrolled nurses may work under the direction and delegation of a registered health practitioner."[3]

In 2019, of the 2391 ENs practising in New Zealand, 156 identified "perioperative care (theatre)" as their primary clinical area. Although this number may appear low (6.5 per cent of the EN workforce), what is interesting is that, of the 30 clinical practice areas identified, "perioperative care" was the third highest. Continuing care (elderly) ranked at number one and assessment and rehabilitation at number two.[4]

The perioperative environment is a clinical area reliant on inter-professional teamwork where team members respect the contribution of each discipline's unique skills, knowledge and scope of practice.[5,6,7] It is also an environment where ENs can participate as members of the collaborative perioperative team in the role of scrub and circulating nurse, under the direction and delegation of a registered nurse (RN) or registered health practitioner.[7] The role of the perioperative EN is supported by the perioperative nurses college's knowledge and skills framework. This states that *"Perioperative ENs and RNs have interchanging roles across perioperative settings"*, while acknowledging that the EN works under the direction and delegation of the RN.[7]

Perioperative clinical manager at Burwood Hospital Diane Darley runs a department of 25 fulltime-equivalent (FTE) RNs and 5.3 FTE ENs. She emphasises that perioperative nursing care requires "a team approach", and explains that in her department, which cares for adult non-acute surgery, senior staff "do not differentiate" between RNs and ENs when allocating the scrub and circulating nurse roles.

As perioperative nurses, communication is a key component when providing care for the unconscious and vulnerable patient.[8] Perioperative nursing, as an EN or RN, provides the vital aspect of holistic care to our patients within the context of multidisciplinary teams. Consequently, the perioperative environment is a clinical area where ENs contribute to nursing assessment, implementation and evaluation of care, working in a team under the direction and delegation of either an RN or a registered health practitioner.

As Dianne Martin, chief executive of the Registered Practical Nurses Association of Ontario, says: *"What an enrolled nurse can or cannot do should be based on their scope of practice"*.[9] •

Perioperative care is becoming a popular area of work for an increasing number of ENs.

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Juliet Asbery, RN, NP, MA, PGDipHsc, works at the Wellington Plastic Surgery Institute and is chair of the PNC (NZNO).

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Support for ENs at Burwood

By Anne Manchester

Some enrolled nurses view operating rooms as rather scary places in which to work. Not so for long-time EN Karen Sword.

Karen Sword has worked as an enrolled nurse (EN) at Burwood Hospital in Christchurch for 38 years. It's where she trained in 1982 and from where she will most likely retire sometime in the next 15 years.

For her first six years she worked in a variety of areas, including geriatric wards, orthopaedic rehabilitation and the plastic surgery unit, where she worked with burns patients helping with dressings and saline baths.

In 1988, she began working in the theatre suite, which was open 24 hours a day, seven days a week, with orthopaedic and plastic surgery included in their responsibilities. Sword enjoyed the acute plastics work she became involved with, including helping with the re-implantation of limbs or fingers.

"In 1995, the plastic surgery unit was moved to Christchurch Hospital and Burwood took over orthopaedic elective surgery Monday to Friday, 7.30am to 9.30pm, with no night shifts or weekend work involved. This suited me really, as by then I had had my first child," Sword said.

Sword enjoys working in the operating room (OR) and believes there is a lot of scope for ENs to increase their skills if they are willing to extend themselves. She is one of six or seven ENs working alongside a team of about 45 RNs. These numbers ensure a good skill mix, with either one EN and two RNs in a team, or two ENs and one RN. Either way, an RN is always there to perform an instrument and swab count, and to provide the EN with the necessary direction and supervision.

"ENs work very similarly to the RNs in OR, but they must ensure they keep within their scope," Sword said. "Some see OR as a rather scary place, but this is because most ENs haven't considered this an area in which to work. A number of EN students doing the 18-month programme at the Ara Institute of Technology have come here for their practical experience. And a couple of these students have secured EN positions here after they have graduated.

"Two ENs on the Canterbury regional committee – Marie Hurst and Michelle Prattley – present awards and discuss EN work at ARA. ENs are making great progress in all sorts of environments now, from outpatients to eye surgery and in the community."

Sword appreciates the support Burwood Hospital has always given ENs – the fact the EN school was once based at the hospital probably contributes to that support. However, it is not all plain sailing in OR, as managing the dynamics within the teams can have its challenges.

Karen Sword (right), scrubbed up for surgery, assists RN Emily Angus as they complete the equipment and swab count.

"I am impressed with some of the younger nurses coming through, including the ENs, who have more confidence than some of us older ones. Their training provides them with the ability to question and reflect critically on their practice."

Sword works seven days a fortnight, a pattern she has maintained since having children. It also helps ensure she keeps a good balance between her work in OR with her interests outside work. "OR work is often quite heavy and stressful. There are heavy instrument crates to lift, you could be standing for many hours on a concrete floor and the nature of some of the surgeries can be very intense. One operation might be expected to take 30 minutes but could end up taking two or three hours if there are complications. This means meal and toilet breaks are sometimes difficult to manage. Nurses are prone to injury in this environment too, especially back, neck and shoulder injury. I did get a back injury when I stared in OR back in 1988 and it still niggles me a bit."

Work in OR became very quiet during the recent lockdown, however, with only a few urgent spinal surgeries performed. The nurses were deployed to the wards, with a few electing to help out in rest homes or on the ward set aside to care for patients with COVID-19 from Rosewood Rest Home. Sword had two weeks' annual leave already booked, then helped out in older person's health and staffing the hospital's main entrance. This involved screening people as they arrived for outpatients appointments, and asking their support people to wait in their cars. "It was hard having to ask people not to provide the support they would normally offer their friends and family."

Work was picking up again by mid-May however. Level-2 restrictions still meant

having to be careful in the admitting unit, avoid having too many people waiting and ensuring social distancing was maintained.

Professional development

Sword is now on the highest level in her professional development – "accomplished". In 2009 she completed a transition programme to bring her qualification up to level 5, in line with the new 18-month programme. Reaching this level means she has to complete a competency portfolio every three years, with an interim report, signed off by a senior nurse, in between each three-year cycle. Over the years the portfolio requirements have been refined, she says, with an emphasis on quality, not quantity. Case studies, conference presentations she has either given or attended, and any quality changes she might have initiated are included, along with her role as the health and safety rep for the OR suite.

"Attending the annual EN conferences can also go towards portfolio assessments but, unfortunately, getting funding from the district health board to attend these events has been getting increasingly difficult," Sword said. "Medical companies used to offer funding too but that is not happening so much either these days. And most people can't afford to self-fund, especially if the conference is being held outside their own location."

As well as being a member of the Canterbury/West Coast EN section and on last year's EN conference committee, Sword is a member of NZNO's perioperative nurses college and on its conference committee. Outside of work, she is a qualified aroma touch therapist and Bowen therapist, offering soft tissue manipulation. She runs a home-based clinic and aims to expand her skills in both these areas in the future.

At Burwood she helps facilitate, with one other nurse or clinical psychologist, a weekly guided meditation programme for nurses called Sankalpa. "Our executive director of nursing and midwifery Mary Gordon heard about this workplace wellness programme from two staff members – Jenny Gardiner and Stu Bigwood – who had attended a Sankalpa session in Australia. Mary was supportive and decided to bring the programme to Canterbury. It is still in its infancy here, though mental health and emergency department nurses are using it and noting its benefits. I would like to see more managers supporting this programme."

Looking back on her EN career, Sword regrets she did not do her RN training. "In 1995/96, a number of my friends undertook a bridging course and became RNs. But at the time, not earning a salary for three years was not an option for me. In hindsight, it probably would have been worth the effort."

While Sword believes ENs offer a great second-level nursing qualification, she would like ENs who later decide to take their nursing career a step further to be able to cross-credit some of their experience towards a BN qualification. "The bulk of the EN workforce is due to retire in the next 10 to 15 years. Maybe more people would train as ENs if this sort of transition was possible," she said. •

Caring for those with addictions

Helping those addicted to alcohol and/or drugs on their recovery journey has been very satisfying for a Northland EN.

By Teresa O'Connor

Charmaine Parker is an utterly committed enrolled nurse (EN). That commitment has been demonstrated throughout her career – from her battle to retain her registration to her commitment to a two-and-a-half-hour commute daily to the only EN job she could get in Northland, to her fierce defence of the place of ENs in the nursing workforce.

Parker was brought up on a farm in Ohaeawai in the mid North and started her EN training in 1983 – "the caps and capes days" – at Whangārei Hospital. After graduation she worked across all wards at the hospital and then moved to Middlemore Hospital, working first in orthopaedics and then in a specialist psychiatric orthopaedic work, caring for those whose injuries were the result of self harm.

Her career then took "a total detour" into sales and management. She was very good at it. She believes her success – in a vast range of products from rental cars to cosmetics, recruitment to the advertising manager of *National Business Review* – was due to her competitive nature, honed in the many sporting codes she was involved in growing up. But after 20 years, she wasn't getting much satisfaction anymore. "I was just crunching numbers and felt a real calling to return to caring for people."

That calling saw her return to Whangārei to look for a job. Her return coincided with her receiving a letter from the Nursing Council outlining yet another change of title for ENs to nurse assistants (NAs) and a new scope of practice. ENs had a few months to re-scope to retain their registration. The Nursing Council had provided guidelines on what was required for such a course but no polytechnics were providing them – Parker had rung them all. Determined not to lose her EN registration, she rang many hospitals explaining her situation. Eventually, the educator at Taranaki Base Hospital offered her a three-month course which fitted the council's NA registration requirements. Parker upped sticks again and moved to New Plymouth. "The whole situation was yet another EN debacle."

'It's a privilege to work with people in the midst of crisis to help them, to be their hope until their own hope kicks in . . .'

Her commitment has also been re-

Charmaine Parker talks with a client.

flected in her fierce defence of the role. "I am constantly asked – like every second day – why I don't do my registered nurse [RN] training. I find that insulting – it devalues the EN qualification. It's as though, as an EN I am nothing, but as an RN I would be something. It's like saying to an occupational therapist, 'Why don't you do you social worker training?'"

Keeping connected to clients

Her decisions to become and remain an EN were deliberate. "We want to keep a connection with our clients. RNs, particularly as they move up the ranks, begin to lose that in a morass of paperwork. I knew when I started nursing, I didn't want to be a manager. I wanted a lot of contact with clients, that's my buzz."

Once she had completed her course, Parker was unable to find an EN job for close to a year. "EN jobs were rarely advertised in Northland and if an EN left a position, they were replaced with a health-care assistant or an RN. There was little support for ENs and few were employed in hospitals."

Eventually an EN role came up – a 0.8 full-time equivalent position as a nurse in the five-bed, inpatient detoxification unit at Dargaville Hospital. The job included managing clients' detoxification, administering supportive withdrawal medication, screening for withdrawals, relapse prevention planning and group facilitation.

While working at Dargaville, she also worked part-time in two different nursing roles in Whangārei as she wanted full-time work.

Direction and delegation

She loved the detox role, working with people who also had co-existing mental health problems. She worked mostly on her own in the unit, with a clinical nurse manager, RN or doctor readily available. "It's a common misunderstanding that, as an EN, an RN has to be on the ward telling us what to do all day. Under the new scope, we are competent to practise, but there must be someone we can access for clarification or if we need assistance – that's what direction and delegation means."

Eventually the long commute took its toll. In 2018, after six and a half years, she decided to try to get a job locally. She got a maternity cover role in April last year as an alcohol and other drugs (AOD) clinician for the community mental health and addictions team in Kamo, Whangarei. While her experience in the detox unit has been valuable, she has been on a steep learning curve. Supporting clients while they are living in the community is vastly different to supporting them in an inpatient unit. She also has been working with "meth" clients – in the methamphetamine harm reduction programme, Te Ara Oranga, a regional pilot collaboration between the police, non-governmental organisations and Northland District Health Board (DHB). It has been running for three years and may be rolled out nationally.

Parker loves working with clients "who are completely changing their lives. Usually, clients have experienced trauma and their journey to recovery is impressive". Those she works with are working to make very fundamental shifts, something Parker finds "very inspirational".

It's a privilege to work with people in the midst of crisis "to help them, to be their hope until their own hope kicks in, as they work their way out of a crisis and have a plan moving forward".

Understanding the cycle of addiction is essential and Parker said life can deal out some harsh blows to people, who sometimes return to their addiction to cope. "We stress they must not let shame or embarrassment stop them from coming back to our service." Whānau support is also an important part of the service.

She is finishing up in the role this month and is opening a private detox and rehab facility, under the direction and delegation of clients' GPs, using all her clinical and life skills to assist clients in their recovery.

She condemns society's "judgemental and very discriminatory" attitude to those with addictions. "I've never met anyone who doesn't use something to deal with unmanageable stress, be that food or shopping."

Promoting ENs locally

Parker is also deeply involved in promoting the EN cause locally, as chair of the local EN section (she's secretary of the national comittee too), as an EN representative on Northtec's nursing advisory committee and on the DHB's professional development and recognition programme.

She's determined other ENs will not have the same difficulties getting work in Northland as she did. That determination has seen her work with the DHB's director of nursing, Deanna Telfer, who is "highly supportive" of ENs, and with Northtec to re-establish EN training.

That work came to fruition this year with the establishment of the country's eighth EN training course. There are 18 students on the course and enough interest to warrant a July intake, but a mid-year intake has still to be confirmed.

She remains very grateful for her father's admonition to "get a qualification once you leave school, so you'll always have a qualification to fall back on later in life. Then you can do whatever you like".

Doing what she likes remains supporting some of the most marginalised in her home town of Whangārei. •

Dialysis at home – an EN's role

A newly-minted enrolled nurse is loving her first job.

By co-editor Teresa O'Connor

Paula Herbert has wanted to be a nurse since she spent a week in hospital 12 years ago with her seven-year-old son, who had a broken leg. "I thought 'I want to do what these amazing people are doing'. The idea rattled round in my head for years."

But family commitments – she has four children, aged 22, 19, 16 and 11 – made pursuing her dream difficult. But she couldn't stop thinking about it and one day in 2017 she came home from work as a teacher aide in her home town of Milton and decided "now is the time to do it".

She enrolled in the 12-month certificate in health at Otago Polytechnic. "It was a long time since I'd been at school and the first day was very daunting. I was the oldest there but everyone was great."

She then applied for the EN and registered nurse courses but opted for the EN training. "I decided, at this stage of my life, an 18-month training appealed more than a three-year course."

'Amazing support'

She wasn't the oldest on the course. "There were school leavers through to two women closer to my age. There were 19 students on the first day, 18 on the second and nobody else left. We had an amazing class. I really enjoyed the study and the support we got was amazing."

Herbert enjoyed all her placements but aged care and district nursing particularly appealed. After passing State finals in August – following a nervous day awaiting results, due to a technology glitch at Nursing Council – she decided not to rush into applying for a job. A position in home haemodialysis was advertised in October and Herbert applied.

She was invited for a screening interview. "I had to ask a friend what that was. After that, I was called back for a formal interview and was told later that day I had the job. I was bouncing off the walls. I didn't think I'd have a chance, given my age and the fact I had no experience."

She was the first new graduate EN employed onto the home dialysis team, entirely staffed by ENs. Another has recently been taken on. Four weeks' training in the haemodialysis unit at Dunedin Hospital with an RN preceptor was followed by three weeks' on-the-job training in the community with the four-strong EN home dialysis team. Working autonomously from the start was challenging. "I knew that was what the position entailed but actually doing it was challenging. I consulted with my colleagues back and forth, and double checked, even if I felt I knew the answer. It was a confidence thing for me."

Herbert is now working independently, secure in the knowledge help is just a phone call away. She has a number of clients, including a woman in a rest-home and a person in their 30s living with their mother. Dialysis can take from four to six hours, depending on the client, and each client has home dialysis three days a week.

When looking after the woman in the rest-home, Herbert arrives at 7.30am. "It takes around 30 to 45 minutes to get fully set up. Once the machine is ready, the patient is weighed – everyone has a target weight – and I take their baseline obs. Their blood pressure is taken half hourly during the treatment, half an hour before the treatment is finished and again once treatment is finished. And they are weighed again."

While dialysis is underway, Herbert chats to her patients – "I have no trouble holding down a conversation".

Once the treatment is finished, all observations are documented in the patient's folder – which they keep at home – the machine is disinfected, wiped down and the room tidied.

'A huge thing to cope with'

The younger patient, who has dialysis for six hours, prepares their own machine. Herbert sympathises with the restrictions the treatment imposes. "It's huge to be confined to your home for six hours, three days a week. Having home dialysis means more independence but it is still a huge thing to cope with."

Paula Herbert with a home dialysis machine.

Lockdown imposed some challenges. During level 4 Herbert stayed at home. In level 3, she looked after two patients and is now fully back on board.

Herbert spends a day a week at the dialysis unit. She enjoys the change and catching up with colleagues.

She knows she is still learning but growing into the role. "If I am concerned about anything, for example if a patient is cramping up a bit or feeling light-headed, I can just pick up a phone and get the support and information I need. My EN colleagues have a wealth of knowledge and experience. I'm really enjoying it. Every day is different and I love having the time to talk with patients, particularly the older ones."

Six months into her long-held dream career, Herbert has no regrets. "Apart from having kids, this is the best thing I've ever done." •

ENs want review of their scope

A survey of ENs has revealed widespread ignorance of their scope of practice among other regulated health professionals, and inconsistency in the application of direction and delegation.

By co-editor Teresa O'Connor

The need to practise under direction and delegation is the most restrictive aspect of enrolled nurses' (ENs) scope of practice, according to nearly 68 per cent of ENs. And only 37 per cent of ENs believe registered nurses (RNs), nurse practitioners, directors of nursing, work-place educators, midwives and other regulated health professionals understand the EN scope of practice.

These are the key findings in a just-published draft report of an NZNO survey of ENs, conducted late last year.

NZNO's national EN committee wants the Nursing Council to review the EN scope of practice in light of these survey results, which come as no surprise to section chair Robyn Hewlett.

Restricting ENs' practice

"We've been hearing for a long time that direction and delegation is restricting ENs' practice. Direction and delegation is not about looking over an EN's shoulder for the eight hours of nursing care they give – it is about working together. Do registered nurses [RNs] look over healthcare assistants' shoulders? No."

The section would like to see direction and delegation replaced with wording along the lines of 'ENs practise in collaboration with . . . ', Hewlett said.

Commenting on the fact that many RNs and other regulated health professionals did not understand the EN scope of practice, Hewlett said undergraduate nursing courses should provide more education on the EN scope, the health care assistant (HCA) role and RNs' responsibilities when working with ENs and HCAs.

Comments from survey respondents included:

- *"Very reliant on the personal perception of others in what direction and delegation means."*
- *"Large inconsistencies remain with this, as you are either micromanaged to the point of the RN overseeing ALL your clinical practice (ie administering meds) or the opposite of a laissez-faire attitude and you're left isolated without any support mechanism."*

Hewlett was also unsurprised by the inconsistency in the application of direction and delegation highlighted by some survey respondents. "We've known about this for some time. We have a standardised curriculum for the EN diploma, but we do not have standardisation of how ENs can practise once they are nursing."

'We have a standardised curriculum for the EN diploma but we do not have standardisation of how ENs can practise once they are nursing.'

Such inconsistency was not fair on ENs, as it impeded their ability to work to their full potential. Medication administration was one area where there were major inconsistencies, despite it being allowed under the EN scope.

The survey was conducted because NZNO's EN section believed a full review of their extended scope – introduced in 2010 – was timely. It was undertaken late last year on SurveyMonkey and attracted 746 responses – a response rate of 57 per cent. NZNO principal research Jinny Willis developed the survey in collaboration with the section but it was not confined to section members.

Almost half of the respondents (46.6 per cent) were aged 55-64, with 16 per cent aged between 45 and 54 and 13 per cent aged over 65. Twenty-one per cent were aged from 24 to 44, with just three per cent under 25. These figures align closely with the age of ENs in the country overall.

Twenty per cent have worked as ENs for more than 40 years, with 36 per cent having worked between 21 and 40 years.

And unsurprisingly, given the age of the respondents, almost 66 per cent intend to retire within the next decade – 35 per cent within the next five years. These figures have significant implications for the nursing workforce, according to Willis.

District health boards (DHBs) are the major EN employers, with 48 per cent of respondents working in DHB in-patient services. DHB community services employed nine per cent. But employment at DHBs varied. Fourteen per cent of respondents (n=26) indicated that ENs were employed throughout their DHB, 6.6 per cent (n=12) reported restricted options for ENs in DHBs, and 8.7 per cent (n=16) commented that either jobs were not available or were not advertised.

Aged care is next biggest employer of ENs, with 15 per cent of ENs working in the sector, and private surgical hospitals employ five per cent. General practice employs three percent, as do non-governmental organisations, eg Plunket, with just a smattering of ENs employed by a range of other providers.

Few ENs working in aged care (16 per cent of the 256 nurses who responded to this question) are involved in InterRAi assessments. The majority (48 per cent) did not have access to InterRAI training or tools and 36 per cent said InterRAI was not applicable to their work.

Significant variations

Just 13 per cent (n=50) of ENs working in primary health care carry out immunisations – 392 nurses responded to the question. And there were significant variations in what those 50 nurses were allowed to do. Hewlett said the section wanted to talk with Nursing Council chief executive Catherine Byrne about the survey results as soon as possible. •

What's missing from the Budget?

Budget 2020, while big on health spend, is short on some crucial details.

By researcher/nursing policy adviser Sue Gasquoine

The Minister of Finance Grant Robertson named the 2020 Budget *Rebuilding together*.[1] Rebuilding from where? And how "together" can it be when its starting point is inequity?

NZNO members work in and contribute skill and knowledge to the care economy. The care economy is part of our social infrastructure, defined by the Council of Trade Unions as" *"the bedrock on which physical infrastructure and financial activity rests. Its focus is keeping us healthy, nurtured, and able to reach our potential as human beings"*.[2]

This infrastructure is in need of rebuilding post-pandemic, along with the rest of the economy. The 2020 Budget promised unprecedented support for physical infrastructure, but was less forthcoming on how our social infrastructure would benefit.

There are frequent references in the media to jobs in "shovel ready" infrastructure projects for good reason – they are tangible. Jobs in our social infrastructure are perhaps less tangible, because the product of work in the care economy is not as visible or as easily quantified. It is, however, no less important. There is no purpose for a physical infrastructure without a social infrastructure.

More detail needed

Significant investment into the health and disability sector, including $3.9 billion for district health boards, was announced before Budget day. But more detail about how that money will be targeted is necessary, lest important opportunities to address equity issues are missed. These opportunities include redevelopment of the infrastructure – physical and social – supporting primary and mental health, disability and aged care.

Trades training and apprenticeships have been singled out for special attention in this Budget – $1.6 billion worth.

NZNO reminds the Government of the urgent need for a skilled, diverse health workforce, particularly in aged care, disability and mental health. Low staffing and shortages of the specialist skills needed in these sectors have been starkly revealed by the COVID-19 crisis. The opportunity for training and support to meet this growing need should not be missed. Part of realising this opportunity can be retaining those who signed up for the Ministry of Health's "surge" workforce and recruiting into the health workforce those from the service industries badly affected by the COVID-19 downturn.

Release of review report

There is division among groups representing health professionals about the release of the *Simpson Report*, ie the comprehensive review of the health and disability sector. Some seek its immediate release so its findings can be considered alongside the recovery and rebuilding programmes the Budget seeks to resource. Others conclude this is not the time to further complicate an already complex set of circumstances with findings that are expected to recommend major changes to a health and social sector significantly affected by the pandemic response. However, implementing the report's findings is likely to be another opportunity to address inequities entrenched in our social infrastructure.

The metaphor of women as an economy's "shock absorbers" was debated at a recent webinar hosted by the Public Policy Institute at The University of Auckland. This pointed out the impact of women being more likely to be under-employed for a variety of reasons, including the need to be flexible for non-paid caring responsibilities. It also revealed that women are more likely to: have periods of unemployment; work in the social infrastructure; be workers in the care economy; and earn less over their working lives, so pay less tax and retire poorer. It also showed their ability to contribute to a consumer economy was constrained, they lived longer with long-term conditions and their unpaid caring responsibilities continued well into their later years. All these factors need to be considered in any rebuild of the social infrastructure.

NZNO's 2020 general election manifesto, with feedback from members, is being finalised. It will propose a number of initiatives that are heavily budget dependent, These include:

- Funding the immediate expansion of primary health care services;
- Funding low-cost, age-friendly housing at the levels required to achieve housing affordability for families.
- Resourcing the health sector sufficiently to achieve:
  - equitable access for Māori to all services
  - an internationally bench-marked youth suicide reduction target
  - safe staffing and skill mix in aged care
  - capital expenditure to upgrade and maintain equipment stocks and buildings
  - settlement of all health pay equity claims including for nurses working for Māori and iwi providers.

While there is more to be done, particularly in aged care, NZNO welcomes aspects of the Budget. Acting industrial services manager Glenda Alexander said NZNO welcomed funding that targeted the social determinants of health, including massive increases to state housing and insulation; lunches for 200,000 schoolchildren; and trades training, "because good housing, nutrition and employment are central to good health". •

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By Matt Roskruge

Did Budget 2020 deliver for Māori?

Will Māori benefit equally from the spoils of Budget 2020?

Budget 2020 was always going to be one to watch. With the Labour-led Government seeking re-election and national coffers in excellent shape, economists and pundits alike were predicting notable spending and investment in core services.

The health sector, stressed from prolonged under-investment, was looking likely to be the next in line for a significant boost, following several budgets focused on education. The spending was needed broadly. Much of our health infrastructure was crumbling, operating budgets were beyond stressed, payroll remained lean and there was little left for innovation and technologies, including those which addressed inequalities and improved health access. Some dreamers might also have hoped for a rollback of the contracting and privatisation which has been a feature of the health sector in recent decades.

But then COVID-19 happened. Modern, open economies were ill prepared for the sort of economic devastation COVID-19 would bring, while health systems across the world found themselves deeply stressed or overwhelmed. New Zealand rightly went into lockdown and the Government was left to prepare an urgent financial response.

The budget process might be somewhat of a relic, ill-suited to enabling Māori to realise aspirations of self-governance . . .

Over the next six weeks, Budget 2020 went from something that was expected to be substantial, to something that needed to be remarkable, spending at a level which enabled the economy to survive and provided emergency repairs to areas of the public service whose fragility was suddenly exposed.

COVID-19 brought into stark focus the essential and risky role of health workers, too often taken for granted. The poor shape of our health system went from being tomorrow's problem to one which needed to be addressed yesterday. Scenes abroad of overflowing health facilities, rationed access to care and mortuaries unable to cope made politicians and planners alike suddenly wonder if there hadn't been a few too many corners cut, budgets reduced and issues overlooked. Money was needed from the Budget to prepare the health system for the worst, be it COVID-19 or some future pandemic.

So, where does this leave Māori? Māori were not only entering 2020 under the ongoing cloud of poor health outcomes, but were also likely to be the worst hit by COVID-19. The budget process might be somewhat of a relic, ill-suited to enabling Māori to realise aspirations of self-governance, with the power to prioritise sitting firmly in government hands. But Budget 2020 needed to deliver for Māori. Without that support, inequalities will deepen, while Māori become disproportionately unwell and die.

So, did it deliver? Sort of. Unfortunately, within the cacophony of Budget 2020, it seems Māori were largely overlooked, receiving $900 million in targeted funding, with the $136 million boost to Whānau Ora being the main contribution within the health sector. This funding was certainly welcome and will help provide short-term operational needs.

However, we're left with the impression that government spent little time considering Māori needs specifically. Budget 2020 is a good budget, and will help Māori get through, but does little to address long-term and complex issues of inequity in health outcomes.

The investment in Whānau Ora is a promising start. Whānau Ora enables Māori to make decisions and prioritise investment into culturally appropriate initiatives able to penetrate into rural or isolated areas where the health system has failed in the past. While the exact level is light of what is likely needed and will largely support business as usual, rather than enable long-term strategic initiatives, it is still encouraging.

Looking beyond 2020, hopefully COVID-19 will help focus the minds of decision-makers on investing in health, rebuilding infrastructure, paying fair salaries and improving our health technology uptake. While these priorities are being set, we need to see strong Māori voices and work to invest in infrastructure and technologies which are inclusive, facilitate the participation of Māori in the health system and keep in mind rural, isolated, disadvantaged and discriminated populations. These populations often struggle to access affordable, timely care.

Initiatives needed

Initiatives which increase capacity, create spaces which are culturally supportive, both visually and structurally, reduce out-of-pocket costs in transport and services, have more by-Māori, for-Māori interventions and invest in technologies which address the morbidities that disproportionately affect Māori, are important places to start.

A final note to consider. The Government mobilised remarkable resources to face a massive crisis, one which threatened to harm the general population to the extent they would experience many of the socio-economic outcomes already experienced by Māori. The response to COVID-19 was absolutely appropriate. But Māori may be justified in wondering why the Government wasn't already making every attempt to address the existing crisis, and whether recovery will be as equally felt as the crisis seems to be. •

Matthew Roskruge, PhD, Te Ātiawa, Ngāti Tama, is the co-director of Te Au Rangahau and a senior lecturer, School of Economics and Finance, Massey Business School, Massey University.

The Nursing Education and Research Foundation (NERF) has the following scholarships available:

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Nominations from employers are invited for this prestigious award:

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Applications close at 4.00pm on 17 July 2020

THE NEW ZEALAND NURSING EDUCATION AND RESEARCH FOUNDATION

Concussion Guidelines – Do NZ Clinicians Use Them? *Take our Survey*

What is the survey about? Do NZ concussion clinicians use clinical practice guidelines? What do they like or dislike about currently available guidelines? Are there gaps? What makes a guideline useful? These are some of the things we are seeking more information about in ournew study.

In our survey (see link below) we ask questions about barriers and facilitators to guideline use by concussion clinicians. The survey will take five-10 minutes of your time and your responses will be anonymous. Please send the link to others you know who work with concussion. Thank you in advance for your thoughts. We will circulate the findings once these have been analysed – here's the link to the survey:

https://is.gd/concussionguidelines **Thank you!**

NZNO Young Nurse of the Year 2020

Nominations now open!

Purpose of award:

- To recognise and celebrate the often exemplary work of nurses in the younger age group who may still be in the early stages of their careers
- To encourage younger nurses to demonstrate their commitment to and aspirations for the nursing profession in Aotearoa New Zealand
- To provide an incentive for them to remain nursing in Aotearoa New Zealand.

Nomination criteria:

The public, colleagues or managers may nominate a young nurse for this award. Nominators are requested to specify how the nurse they are nominating demonstrates commitment and passion to nursing beyond the every day. This may include how the nurse:

- Shows compassion or courage beyond what is expected in their role as a nurse;
- Has improved care or health outcomes for their patients through their commitment to care, leadership, research or quality;
- Works to deliver care that honours the articles of Te Tiriti o Waitangi: Tina Rangatiratanga; Partnership; Active protection; Options and Equity.
- Has overcome major challenges to deliver exceptional care.

Nominees may be registered or enrolled nurses, may be new graduates, do not have to be in paid nursing work, must be under the age of 31 as at December 31st 2020, be resident in New Zealand, and a current financial member of NZNO.

There is a two phase nomination assessment process:

- Firstly, shortlisting of up to 6 nominations by a subcommittee of the YNYA assessment panel convened for that purpose and comprising NZNO staff, Te Rūnanga representation, and a previous recipient of the YNYA and using the criteria above.
- Then an opportunity for nominators and nominees on that shortlist to 'meet' the full YNYA assessment panel, by Zoom or similar, to respond verbally to set questions made available in advance. Pre-recording (filming) of nominators and nominees responses to these questions may also be an option.

Assessors will be looking for strong, detailed nominations that clearly evidence the strengths, achievements and aspirations of the nominee. In addition to giving evidence of how the nominee meets the criteria listed above, further aspects that the assessment panel will be considering are as follows:

- Is there a particular project that the nurse has been involved in or is it a general, all round nomination?
- In what way are any outcomes demonstrable e.g. has the nurse been accepted onto a programme by merit or have patient outcomes demonstrably improved?
- Has the nominee contributed in a special way to a community or culture that stands out?

The winner will receive a trophy and a cash prize (of which 50% must go toward further education / professional development). Two runners up will receive a runner-up certificate and a book voucher to the value of $200. All nominees will receive a certificate recognising their nomination.

This is an exciting opportunity for young nurses in Aotearoa New Zealand and we encourage you to submit a nomination in recognition of the work of young nurses throughout the country.

Closing date for nominations: 5.00pm, June 30, 2020

Nominations to be sent to: Heather Sander **heather.sander@nzno.org.nz**

For Nomination Form and further information/criteria go to: www.nzno.org.nz or www.nznursesstation.org

Are ratios really the answer?

Are ratios superior to care capacity demand measurement in determining safe staffing levels for patients? NZNO thinks not.

By CCDM coordinator Maree Jones

Health policy reforms in New Zealand during the 1990s had a damaging impact on the nursing workforce and on patients, an impact we are still feeling today.

This has been well documented in the research, including *Effects of Health Policy Reforms on Nursing Resources and Patient Outcomes in New Zealand*, published in 2010.[1]

This important research documents how the health reforms of the 1990s saw nursing in this country lose control of nursing budgets. In many instances, these budgets were given to generic managers from industries other than nursing. This replacement of senior nurses in management resulted in a loss of years of essential senior nursing and midwifery experience and practice wisdom. Nursing leadership is now, in the main, confined to professional leadership or advice, rather than budget holding.

To this day, this situation, along with a lack of accurate outcomes and patient acuity data, has severely limited the ability of nurses to defend both their quality of care and the quality of their practice environments.

Big drop in nursing hours

A 2005 study by registered nurse Barbara McCloskey found that, between 1993 and 2000, available nursing hours in this country fell 36 per cent.[2] Over the same period, the demands on nurses had increased as a result of shorter patient stays, higher patient acuity and fewer nurses dealing with sicker patients.

This is the situation our clinical nurses and midwives still find themselves in today. And it continues to be detrimental to patient safety and outcomes and our ability to recruit and retain adequate nursing and midwifery workforces.

Many district health boards (DHBs) are still using historical methods to calculate their nursing and midwifery staffing levels – methods that do not account for the acuity and complexity of patients and their real care needs. Instead, these methods count a patient as a patient as a patient and a nurse as a nurse as a nurse.

'Basing nursing and midwifery staffing on the actual acuity of patients, according to professional judgement of the nurse or midwife caring for them, is an accurate way to determine staffing against real patient need.'

In some countries, nurses have fought hard for, and achieved legislated nurse-to-patient ratios. In the main, these also count a patient as a patient as a patient and a nurse as a nurse as a nurse.

In Queensland, nurse-to-patient ratios were legislated and implemented in July 2016. The drive for ratios in Queensland came from the crisis that arose after the former Liberal National Party Government slashed 1800 nursing jobs between 2012 and 2015 across Queensland Health. This included positions in operating theatres, intensive care units, emergency medicine, maternity services and mental health.[3]

According to nurses in Queensland, this led to a nursing crisis that saw a mass exodus of nursing experience, skills and knowledge, many leaving the profession due to the clinical pressures. This was severely detrimental to patients and nurses.

At its annual conference in July last year, the Queensland Nurses and Midwives Union (QNMU) reported that since the introduction of ratios, research estimates 145 deaths have been avoided; 255 readmissions have been avoided, saving $1.2-$2.4 million; and 29,200 hospital days have been avoided, saving $54-$81 million. The research also showed improved staffing levels led to better patient outcomes in facilities where the ratios legislation was implemented.[4]

Such results are not surprising given the decimated state of Queensland's nursing and midwifery workforces before the introduction of the ratios. Any increase to nursing and midwifery numbers in the circumstances would have resulted

CCDM FTE calculation method		compared to	Queensland ratios method
Care for all patients			
Rosters are based on the nursing care hours needed for patient care for all patients, on every shift. Nurses and midwives provide this information via the acuity system.	Yes	No	Rosters are based on the number of occupied beds counted three times a day. They are not based on the care hours needed for all patients.
Right staffing now			
The MECA states that all DHBs must implement CCDM according to the CCDM methodology by June 2021. National reporting shows slow uptake of CCDM FTE calculations across DHBs in New Zealand. Nursing and midwifery workforce shortfalls are predicted to continue.	No	No	Ratios have been mandated since 2016 for every publicly-funded Hospital and Health Service (HHS). However not all HHS have fully implemented ratios. Currently there is a campaign to improve the day-to-day use of ratios and compliance. Nursing and midwifery workforce shortfalls are predicted to continue.
Shift coordination			
The FTE calculation includes separate hours in the roster for the coordinator in charge of the shift, where needed. These hours do not include a patient workload.	Yes	No	In the Queensland method, the coordinator in charge of the shift is included in the direct care ratios. They do not have separate hours allocated for shift coordination.
Leave entitlements			
The staffing budget takes into account the MECA provisions for all leave types, eg annual, shift, long service etc. Adjustments are made to the staffing supply which makes sure leave can be taken.	Yes	Yes	The Queensland method takes into account the industrial agreement for all leave types. A leave loading is added to the roster. This calculation may mean leave cannot always be taken.
Professional judgement			
Staffing is based on your professional judgement about patient acuity every day, every shift. Acuity data forms the basis of the ward roster.	Yes	No	Professional judgement is used to complete a service profile which contributes to staffing decisions. Professional judgement about patient acuity may not be accounted for every day, every shift.
National monitoring			
Safe staffing is monitored using standard measures from the national CCDM core data set. This includes counting shifts that are short of staff (Shifts Below Target).	Yes	No	Each HHS decides the safe staffing measures it will report on for its organisation. These measures may not include counting shifts that are short of staff.

For more information go to ccdm.health.nz or Queensland Health Business planning framework: a tool for nursing and midwifery workload management at https://www.health.qld.gov.au/__data/assets/pdf_file/0035/666908/bpf.pdf

in improvements. All contemporary research tells us the greater the number of registered nurses on duty, the better the outcomes for patients.[5,6,7,8,9]

Given the current nursing workforce crisis in this country, in which DHBs struggle to recruit and retain enough nurses and midwives, one would expect similar results here.

But is just increasing the number of nurses across the board, using a blunt ratio, really addressing the care needs of patients?

Patients need nursing and maternity care hours that meet their individual care needs. Ratios, con the other hand, work on the assumption that every patient's care needs in a particular ward are the same. This is bound to cause inequities in workloads. While ratios may be sufficient to cover nursing workloads in lower acuity areas, it is unlikely they would be sufficient in wards in tertiary hospitals, where nurses are providing care, in the main, to acutely unwell patients.

Basing nursing and midwifery staffing on the actual acuity of patients, according to the professional judgement of the nurse or midwife caring for them, is an accurate way to determine staffing against real patient need. Acuity systems like TrendCare collect this information for nursing and midwifery.

The care capacity demand management full-time equivalent (CCDM FTE) calculation method uses acuity data to determine accurate staffing. Independent evaluation of this method tells us it is a valid methodology to accurately match nursing and midwifery resource to the real care needs of patients.[10]

And yet, due to DHBs' resistance and their slow, patchy implementation of CCDM, especially the FTE calculation component, nurses and midwives working in our public hospitals are still not working in safely resourced environments. And patients are not always receiving the package of nursing/midwifery care they require on a shift-by-shift basis.

It is no wonder nurses and midwives are desperate for a solution and, once again, are looking to ratios as a quick way to relieve their staffing pain and suffering. But we should be careful.

As soon as ratios were introduced in Queensland, the QNMU raised concerns about how the ratios were being interpreted and applied in public hospital wards. The QNMU's campaign *Ratios Save Lives – Phase 2* and their recently launched *Ratios Save Lives and Money –Phase 3* campaign are demanding better compliance. The union wants to see professional nursing and midwifery judgement and consideration of patient acuity data, where available, used to support increases in staffing levels. This additional information is being sought when it is deemed ratios are not providing sufficient nursing hours to meet patient acuity.[7]

The QNMU is also calling for the establishment of legislated penalties (currently there are none) for hospitals that do not comply with the legislated ratios; exclusion of the ward shift team leader from the shifts ratio; and easy-to-understand public reporting, in real time, on hospital compliance with the ratios.[11]

Late last year, in response to questions from our members and others in the sector about Queensland's legislated ratios, NZNO undertook an in-depth look at the Queensland ratios and compared them with the CCDM programme and the CCDM FTE calculation. The table on p27 documents the results.

On the surface, ratios appear to be a quick fix to the very real staffing pain our nurses and midwives are suffering. However, as nurses and midwives we should ensure we are well informed and we should think deeply about advocating for legislated ratios over a system already embedded here to determine safe staffing – the CCDM FTE calculation.

The CCDM FTE calculation is wholly based on nurses' and midwives' judgement of the real care needs of their patients via a validated patient acuity system. International evidence tell us that acuity-based staffing is linked to decreased adverse events for patients, including falls, infections, and pressure ulcers.[12]

The 2015 independent evaluation of the CCDM programme FTE calculation concluded that *"the CCDM programme's calculation of estimated FTE requirements for DHB wards is based on a sound and appropriate methodology"*.[10]

But is just increasing the number of nurses across the board, using a blunt ratio, really addressing the care needs of our patients?

Patient acuity data offers transparency that allows accurate calculations of how many nursing hours are needed at any given time, on any given ward, on any given shift, according to patients' real care needs. And it will keep pace with the increase in patient acuity we have seen over the past decades. Conversely, ratios treat a patient as a patient as a patient. Nurses and midwives on the clinical floor know only too well this is not their reality. •

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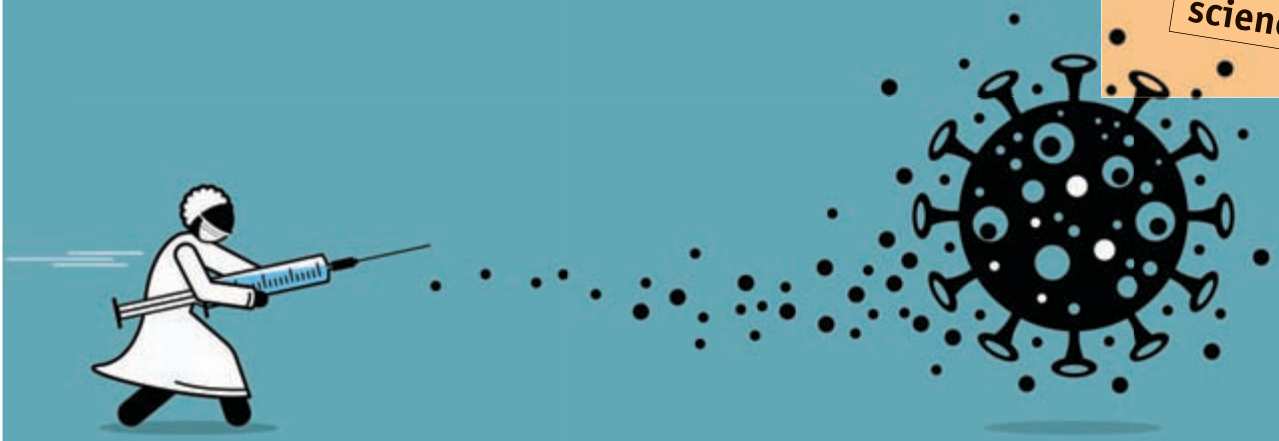

GRAPHIC: ADOBE STOCK

A vaccine for COVID-19?

COVID-19 vaccine development has been accelerated, but ensuring safety is vital.

By Georgina Casey

SARS-CoV-2 – the coronavirus (CoV) responsible for the COVID-19 pandemic – is from a large family of viruses composed of a single strand of genetic material with associated proteins. Single-strand viruses have very high mutation rates, which is why the influenza virus requires new vaccines each season. Fortunately, even though SARS-CoV-2 has frequently mutated since entering the human population, few of these changes have occurred on the spike protein that is the key target for vaccine development.[1]

The purpose of a vaccine is to create a large number of immune people in the population so the virus cannot easily spread (herd immunity). The proportion of a population required to be immune to prevent community spread of COVID-19 is thought to be at least 60-70 per cent. Natural immunity following exposure to SARS-CoV-2 will also create herd immunity. But the repeated waves of infection that would occur in a global population previously unexposed to the virus would cause huge loss of life and economic devastation.[2]

The desired outcomes of vaccine trials are either protection from infection (the person develops antibodies) or prevention of symptomatic disease/reduction in its severity.[1] But because we don't have accurate data on the true incidence of COVID-19 in the population and the number of asymptomatic infections, it is hard to develop reliable trial protocols. Further, CoV immunity often wanes over time – the CoV that causes the common cold generates very short-lived immunity – so the duration of effectiveness of vaccines will also have to be considered.[3]

Vaccine types being developed include:

- **Nucleic acid vaccines.** These are RNA or DNA-based vaccines based on the genetic sequence of the virus. They can be rapidly manufactured but are susceptible to temperature and other environmental changes. There are no vaccines of this type in clinical use, but early human trials (against other viruses) have shown promise. Questions remain about their effectiveness and safety.[1]
- **Recombinant proteins that mimic the CoV spike protein.** These are slower to manufacture but have an extensive clinical history of effectiveness for other viruses (eg influenza, hepatitis B). They must be administered with adjuvants that induce immune response.[1]
- **Whole live-attenuated or inactivated virus vaccines.** These generate the best immune response in recipients, often with long duration (eg smallpox vaccine). However, they must undergo much more intense safety testing due to the risk of causing a disease response.[4]

Safety is an overriding consideration in vaccine development. Experimental vaccines used in animal trials against some other types of CoV (SARS-1 and feline CoV) showed enhanced respiratory disease on exposure to the virus after vaccination.[2]

Normally it takes decades for a vaccine to enter clinical practice, but human trials have already commenced for COVID-19, often alongside preclinical research.[4] Human challenge trials are being considered – where participants are deliberately exposed to the virus following vaccination. There are obvious ethical issues with this approach, but it could accelerate the development of an effective vaccine and save lives.[5]

Collaboration needed

Developing and distributing a vaccine requires universities, pharmaceutical companies and governments around the world to collaborate to ensure resources are used to best effect.[1] Multiple different vaccines in development mean that there are, potentially, multiple pathways to effective vaccination of the global population.

However, producing the billions of doses needed and distributing them to all communities worldwide, while adhering to cold chain requirements, will be highly complex and time-consuming. •

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How can students manage nurses' di

Nursing students struggling to speak out against unethical behaviours on placement can get help from employers and model respectful care to their supervisors, says a group of University of Auckland nursing students.

By Georgia Dakin, Phoebe Hill, Harsimran Kaur, Rachel Lee, Analise Lockie, Rachel Ma and Kim Ward.

As student nurses entering a clinical setting, we expect to observe registered nurses (RNs) upholding ethical and legal standards of practice.

When witnessing unethical or unprofessional practice, students – with the best of intentions for patient care – should feel able to speak up. But is the clinical environment a place where we feel confident or empowered enough to do that?

During a recent clinical placement in a large metropolitan hospital, a student nurse witnessed a supervising RN using expletives when describing a patient during a bedside handover. The RN appeared to assume the patient – who had advanced dementia – could not comprehend what was being said. But this should make no difference when adhering to ethical and legal standards of professional practice.

Another student witnessed an RN, who had just inserted a catheter, commenting about the patient's genitalia to others and laughing about the catheterisation process.

In both cases, the students understood the commentaries were inappropriate and unprofessional but felt speaking up would bring the RNs' practice into question and negatively affect the social environment and professional relationship. They felt this would jeopardise their learning experiences.

The Nursing Council (the council) defines the expected competencies required for clinical nursing practice. They include practising within ethical and legal standards, and upholding the patient's right to be treated with respect.[1,2]

The above scenarios violated this right. Being respectful includes valuing individuality and treating patients professionally.[2] RNs must also maintain a "*high standard of professional and personal behaviour*" at all times, according to the council's code of conduct.[3]

Both RNs demonstrated unprofessional and disrespectful behaviour towards the student nurse and the patient. The code's principle six and RN competency 1.1 expect intervention from nurses when unethical or unlawful practice is seen.[3,1]

Another student witnessed an RN, who had just inserted a catheter, commenting about the patient's genitalia . . .

Students learning the legal and ethical standards of practice are expected to follow these standards. Therefore, a student nurse would be expected to report to a more senior member of staff if they had witnessed a patient commentary involving expletives by RNs.[1]

Student voice

Scholars claim that human interaction is an essential part of safe practice in health care.[4] According to American health and safety researchers, health-care organisations strive to create a culturally safe environment where every member of the health-care team, including students, can feel safe in voicing concerns for patient care or reporting unprofessional behaviour.[4]

However, this type of environment was not commonly experienced in a 2007 study of United Kingdom (UK) nursing students.[5] American research has also highlighted the prevalence of intimidation in the clinical setting, which can interfere with inter-professional communication, resulting in medical errors and inadequate patient care.[6]

Feeling unable and unsupported to challenge unprofessional RN behaviour is disempowering for a student nurse.[5] A critical incident study in the UK investigating empowerment in student nurses reported that many of the participants felt unable to speak up about the disrespectful, unprofessional behaviour of RNs they witnessed. Researchers suggested that reluctance to speak up came from "fear of reprisal", which reduces the confidence and self-esteem of students.[5]

Students may feel uncomfortable reporting unprofessional practice to senior staff due to fear of negative impacts on their clinical placement.[6,7]

A study of the experiences of belonging, conformity and compliance during the clinical placements of nursing students in Australia and the UK found they avoided "rocking the boat", believing complying would improve their prospects of acceptance by the nursing team.[7] Students expressed fears that speaking up or challenging unprofessional behaviour would jeopardise their clinical learning environment.[7]

Yet, recognition and disclosure of unprofessional commentary is critical to ensure patient safety and achieve optimal patient outcomes.[8]

So, are we students putting patients at risk by not managing colleagues' unprofessional patient commentary? Or should the individual practising this behaviour be solely responsible?

Based on professional and ethical competencies, including advocating for patients and speaking up about unsafe practice, we believe it is the responsibility of both.

Recommendations

Power hierarchies and the desire to conform can make students feel as though speaking up about unprofessional practice, particularly disrespectful patient

srespectful patient commentaries?

commentary, will jeopardise a student's practical experience.[9]

Therefore, it is essential student nurses are aware of strategies to help them feel empowered to speak up about unprofessional RN practice.

American nurse consultant Sharon McNamara suggests using an organisation's resources as a solution for students to speak up about witnessed unprofessional staff behaviour.[6] Resources in metropolitan hospitals include charge nurses and clinical lecturers.[10]

This allows complaints to become anonymous when they are brought to the attention of the nurse in question, helping students to avoid potential direct conflict.[11] Unprofessional nursing practice can be remedied, meaning patient care is less likely to be jeopardised.

In another case, where a student witnessed a health-care assistant laugh and comment about the genitalia of a male patient with a disability, they gave anonymous feedback to the organisation's manager via a university lecturer after completing the placement. They felt raising it earlier would have put the placement environment in jeopardy.

Reciprocal role-modelling

Student nurses can also act as role models for RNs behaving unethically. Research in New Zealand suggests reciprocal role-modelling can be a strategy for student nurses to underscore a colleague's unprofessional behaviour.[12]

In reciprocal role-modelling a student or new graduate nurse displays behaviours that the RN supervisor can learn from. This can include using strictly professional language and behaviour when discussing patients anywhere in the clinical setting.

Such role-modelling relies on an RN and student nurse being willing to engage in a trusting and respectful relationship. Once this relationship is established, the student nurse and RN will have confidence in each other and be able to share information or demonstrate, without fear of being judged. The student nurse should then be able to share new information around best practice with the RN, while still being respectful of the RN's knowledge and experience. This will ultimately provide safer care for patients.[12]

For reciprocal role-modelling to be effective, however, there must be mutual respect between the RN and student nurse. The RN must be open-minded and willing to acknowledge good nursing practice from the student nurse.[12] This is where an organisation's resources can be used to encourage open-mindedness and mutually respectful relationships with students.[6]

Conclusion

Nurses have ethical and legal responsibilities to uphold professional standards, including using professional language when describing patients during clinical handovers. Students also have a responsibility to challenge unprofessional practice from RNs.

However, the pressure to conform and the fear of jeopardising the learning environment can prevent this. Student nurses can use a variety of strategies to address poor RN behaviours. Speaking through mediators (eg a charge nurse/clinical lecturer) can be used where students don't feel empowered to speak up.

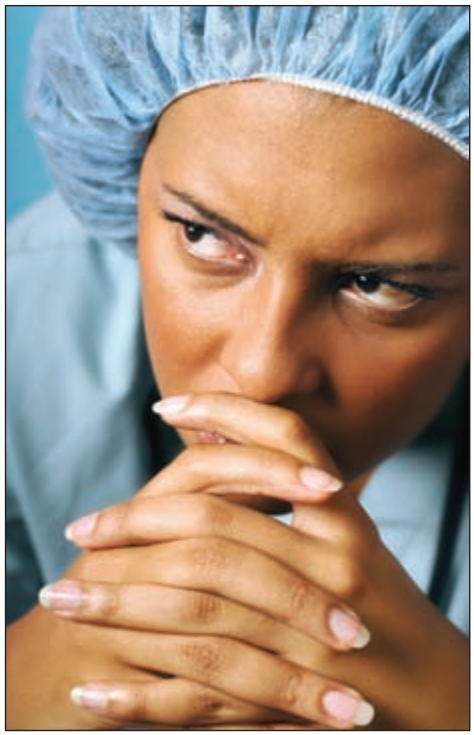

PHOTO: ADOBE STOCK

Many students feel speaking up would jeopardise their clinical placements.

In turn, student nurses can influence the professional standards of an RN's practice through reciprocal role modelling of positive behaviours. •

University of Auckland second-year nursing students contributed this article with the support of their nursing lecturer Kim Ward, RN, PhD.

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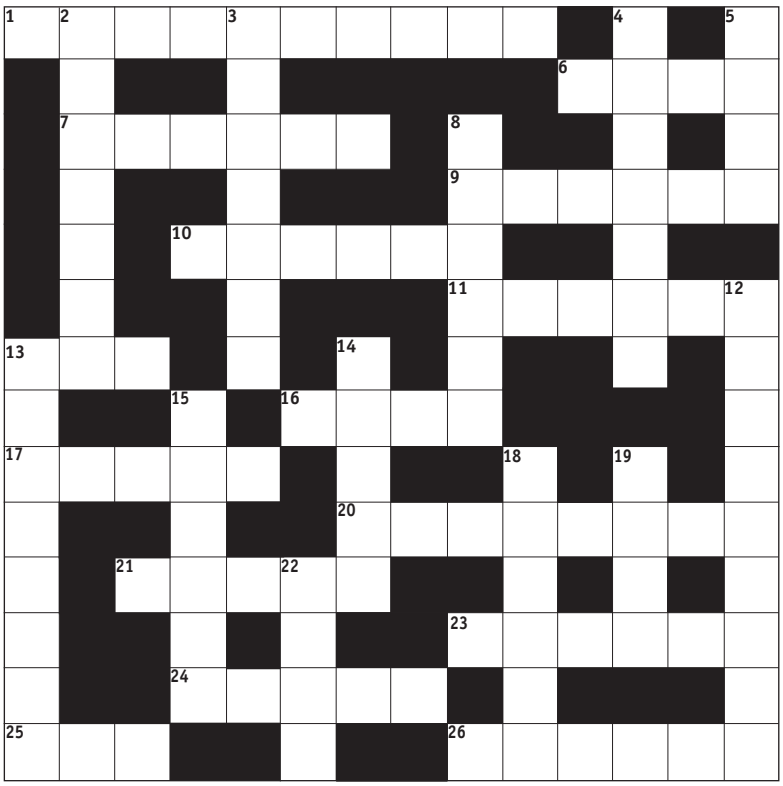
crossWORD

Completing this will be easier if you have read our May issue. Answers in July.



ACROSS

1) Describes system based on popular vote.
6) Plant whose sap soothes burns.
7) Sturdy, vigorous.
9) Rubs out.
10) Principles.
11) Mean to.
13) Years since birth.
16) Agony.
17) Main artery.
20) Voting age.
21) Tiny infectious agent.
23) Work room.
24) Nightly rest.
25) Exercise studio.
26) Lend a hand.

DOWN

2) Protects hearing.
3) Group of infectious cases.
4) Vision aid.
5) Marries.
8) Step down from job.
12) To cleanse of germs/disease.
13) Changing to suit new situation.
14) Regular payment for work.
15) Link between floors of building.
18) Rubs roughly.
19) Mystical knights of *Star Wars*.
22) Freeloader.

May answers. ACROSS: 1. Coronavirus. 6. Oily. 8. Sky. 10. Sputnik. 12. Boot. 13. Ngāruawāhia. 15. Very. 16. Goitre. 17. Den. 18. Whānau. 19. Acre. 21. Mars. 22. Shag. 23. Attend. 24. Sugar. **DOWN:** 1. Cows. 2. Obituary. 3. Anxious. 4. So. 5. Cyst. 7. Isolated. 9. Kotahitanga. 11. Pandemic. 14. Sunnyside. 16. Graphic. 19. Arms. 20. Rung. 21. Moth.

wiseWORDS

“ It’s great going out with the RN – I know the patients and whānau, have built up the trust – patients trust my judgement and will let us in to help. ”

– Enrolled nurse interviewed for NZNO research on ENs in primary care

it’s cool to kōrero

HAERE MAI – welcome to the June kōrero column. The kererū (New Zealand pigeon) is the best known of Aotearoa’s two native pigeons. In Northland, it is also known as kūkū or kūkupa. Kererū are found throughout the country, and live in habitats ranging from native forest to suburban gardens.

The kererū is a big handsome bird, with blue-green feathers and a white vest. They were highly valued by Māori as food – they were one of two foods harvested at Matariki – and their feathers used to make cloaks (kahu kererū) and to ornament food containers.

Kupu hou

New word

- **kererū** – *pronounced “ke-(as in “Ken”)-rrre-(as in “red”)-rrroo”*

New Zealand pigeon

- **Kei roto i te rākau kōwhai, te kererū e noho ana.**

The kererū is sitting in the kowhai tree.

Rerenga kōrero

Phrases

This June issue focuses on enrolled nursing. Here are some phrases used in everyday nursing care.

- **Kei te pēhea/pēwhea koe?**

How are you?

- **He mamae tāu?**

Do you have pain?

- **Kei te hia rongoā koe mō te mamae?**

Do you want medicine for the pain?

- **Kei te whakaruaki koe?**

Are you nauseous?

- **Kei te tēhi mātou i a koe.**

You are going to have some tests.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield. Learn more about kererū at www.doc.govt.nz/kereru

Students Elza O'Brien (left) and Stacey Sanders participate in the emerging learner module before embarking on their clinical placements.

Encouraging nurses into aged care

A new course at Otago Polytechnic aims to foster students' interest and capability in caring for older people.

By Kerry Davis and Rachel Parmee

A new course, senior persons' health, was rolled out earlier this year in the bachelor of nursing programme at Otago Polytechnic.

The year-two course was developed in response to requests to encourage interest and capability among future registered nurses (RNs) to become part of the aged-care workforce. The need for a well-prepared aged-care nursing workforce has been underscored by the COVID-19 pandemic, which has had a devastating impact on this vulnerable population and their providers of care.

Planning for this clinical course included consultation with colleagues from the aged residential care (ARC) sector, allied health, palliative care, the Otago School of Medicine and experts in disability. We have appreciated their collegiality and goodwill in sharing resources. We are also members of a Southern District Health Board (SDHB) working group established to support the recruitment and retention of nurses into ARC.

Theoretical content

Preparation of theoretical content included liaison with the SDHB nurse practitioner in older persons' health, who helped students apply relevant assessment tools, including the Health Quality and Safety Commission's *Frailty Care Guides*, to their case studies. The 20 directed-learning hours include education on medication safety, dementia care, legal issues, elder abuse and mental health, with a strong focus on dispelling stereotypes and fostering person-centred care.

One innovation in the course has been the introduction of a week-long emerging learner module before clinical placement. This involved developing practical skills and experiencing a senior person's activities of daily living. Each student participated in a simulation and guided debrief, based on an older man presenting at a rural general practice with acute delirium in the context of polypharmacy. Lecturers acted out a scenario focused on professionalism. This module will be built upon across courses this year.

The firm favourite with students was an icebreaker exercise designed to foster insight into another's lived experience. This involved immersion in music, such as the songs of Vera Lynn, items and stories that related to a bygone era. Self-awareness was fostered through empathy scoring and exposure to success stories from the ARC sector, such as the involvement of children, animals and music in programmes. Finally, students refined their interviewing skills with a 91-year woman who lives independently. It was rewarding to witness the students' warmth as they enquired about her self-care and her life story.

Theoretical and clinical preparation culminated in 120 hours clinical placement over four weeks in an ARC hospital, rest home or dementia-care facility. Assessment of learning was by clinical portfolio, including evidential requirements encompassing Nursing Council competencies, preceptor feedback and the development of critical thinking skills. The latter was demonstrated through written reflection on the impact of a psychosocial or mental health issue affecting a senior, with links to their personal plan. Another assessment involved the application of an established tool, such as falls risk, pressure injury risk assessment or delirium scoring, in the context of a full resident assessment. So far, 54 students have completed the course, with another 60 scheduled to finish it this year.

The imposition of level-4 restrictions during the COVID-19 pandemic interrupted the third week of clinical placement, presenting a challenge to the continuation of placements. To their credit, many students wished to continue placement so they might support the staff under pressure and assist the soon-to-be isolated residents. Ultimately, concerns that students' movements might present a risk to the vulnerable client population meant few students were able to complete their clinical hours.

The need for a well-prepared aged-care nursing workforce has been underscored by the COVID-19 pandemic . . .

While uncertainty surrounded the return of undergraduate students into some clinical settings, the future is looking bright for this clinical course and for ongoing collaboration in the interest of senior persons' health. Most ARC facilities were not able to offer student placements in level 2, but nurse leaders at Dunedin Hospital and in other settings worked tirelessly to extend existing placements and create new ones. This collegiality was much appreciated. •

Kerry Davis, RN, MN, and **Rachel Parmee, RN, MA,** are senior lecturers at the School of Nursing, Otago Polytechnic.

A pathway for enrolled nurses

After years of lobbying, graduating enrolled nurses finally have access to the same district health board employment application process as their registered health worker colleagues.

By professional nursing adviser Suzanne Rolls

In 2013, enrolled nurses (ENs) understood the need for a pathway into practice for graduating ENs. The following year, NZNO's national enrolled nurse section discussed requirements for newly-graduated ENs and published the enrolled nurse supported into practice programme.[1]

You would think a process supporting ENs as they entered nursing would be welcomed. However, this was not the case. It took years of tenacious conversations, work with willing stakeholders and determined advocacy to achieve an EN graduate programme.

Registered nurses (RNs) achieved the advanced choice of employment (ACE) pathway into practice following a pilot in 2012. This led to the establishment of the nurse-entry-into-practice/speciality-practice programmes. Both these programmes include health workforce funding for clinical supervision, study days, preceptor development and partial funding of salaries. However, the new programmes did not include access for ENs.

In 2018, NZNO, the Ministry of Health (MoH) and district health board (DHB) representatives signed a safer staffing accord. One of its outcomes was employment for all nursing graduates.[2] This required the MoH to open the ACE pathway to ENs. The ministry, DHB directors of nursing and NZNO representatives on the accord set out to ensure the ACE rules were changed.

From this month, graduating ENs will be able to submit their CVs and details to an interim pathway.[3] This will be the first time ENs will be offered the same application process as their registered nursing, midwifery and medical colleagues. A national talent pool of eligible applicants will be created next month. The EN national talent pool will remain open indefinitely, with applicants exiting and entering, based on their ability to meet the eligibility criteria. There will be EN data on the application pathway, information about where graduate employment is available and which employers are not using the enrolled nursing resource.

The graduate ACE process for ENs is welcomed. NZNO seeks a successful launch of its implementation and hopes information about the process will be shared widely.[4] The process is explained on the ACE EN website and via a recorded webinar.[5] Its introduction may be delayed due to the disruption to state final dates and clinical placements caused by the COVID-19 pandemic.

NZNO has lobbied on behalf of, and in partnership with ENs for decades. Many nursing leaders and managers refuse to understand enrolled nursing and ENs' scope of practice. These issues were explored in last year's EN section survey (see news focus on the EN scope of practice, p23). The EN scope is included in RN competencies, with managers having a significant influence on workforce design and skill mix. It is time for nurse leaders and managers to ensure they use all the nursing resource available, and our EN colleagues.

DHBs control how ENs are employed and the ACE process will provide a better understanding of the obstacles. The EN section has collated a list of barriers to enrolled nursing and is systematically working its way through them with stakeholders until solutions are found.

For successful implementation, NZNO believes a reference group that includes ENs is needed. This group would ensure:

- preceptor training for ENs;
- backfill arrangements to ensure professional development is accessed;
- inteRAI education and certification for ENs in aged residential care and needs assessment services;
- immunisation administration training for ENs in primary care;
- ENs are welcomed into the profession and have the same pillars of safe practice as other health workers;
- models of nursing care teams include ENs;
- the process is open to private sector employers; and
- staffing skill mixes include ENs.

We encourage all graduating ENs to use the process.[3,4,5] A funded pathway benefits the whole EN workforce, not just individual nurses. The pathway creates opportunities for existing ENs to be mentors and preceptors, thus using their skills, knowledge and expertise.

NZNO is grateful to EN members and the national EN section committee for being the leading voice for enrolled nursing and courageously championing this profession. •

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2) Ministry of Health. (2018). *Safer Staffing Accord*. Retrieved from www.health.govt.nz/our-work/nursing/developments-nursing/safer-staffing-accord
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The changing industrial environment of COVID-19

Delegates played a key role in maintaining connections between members and NZNO during the levels 4 and 3 restrictions.

By organiser Danielle Davies

Just like a clinical emergency, a global pandemic throws all systems into a heightened sense of urgency. In nursing practice, we are trained to deal with clinical emergencies – we know the leadership required, the emergency crash trolley, the critical care mnemonics. In these situations, all attention and energy is focused on the acutely unwell patient to get them through.

But what happens to members' wellbeing and rights when so much energy is placed on pandemic planning? In this environment, do members still have employment rights? Do collective agreements still apply? Can members be forced to take annual leave or be paid at 80 per cent of their usual earnings? Can members be directed to nurse contagious patients without adequate protections for themselves or others in place?

These were some of the most common questions members asked NZNO throughout COVID-19. With a membership of more than 50,000, answering individual queries only gets the message out so far.

Danielle Davies

However, it was member leaders – delegates – who showed up big time to help guide us all through this trying time.

Just as during a state of emergency, you need boots on the floor reinforcing these answers. You need frontline leaders holding the line.

Just as during a clinical emergency, direct leadership is an essential element to guide us through unpredictable times. With only so many NZNO staff throughout the country, the sheer number of industrial challenges members faced throughout COVID-19 could have been overwhelming. However, it was member leaders – delegates – who showed up big time to help guide us all through these trying times.

NZNO was able to report and advocate on issues such as access to personal protective equipment, special leave pay and casual pay compensation because of the timely updates delegates were giving us daily. With each update, NZNO organisers shared the status and progress of important developments across the organisation – including up to our industrial advisers and our national leads for large employers such as district health boards, aged residential care, Plunket, and NZ Bloods. Not only could we then raise issues with employers directly in real time, but we could also promote best practice across employer groups and emphasise equity across the health sector.

On an interpersonal level, delegates turned out in force to advocate for the safety of members with vulnerable health. This advocacy enabled those at risk to remain safe at home during the pandemic, protecting not just their own health but also that of others in their bubbles. It was in this advocacy that delegates combined their nursing training – to protect the health of others – with their industrial advocacy – to stand up for the rights of their fellow members. The result was a group of members whose health and employment conditions were protected during these unprecedented times.

New ways to connect

With lockdown restrictions in place, NZNO organisers were unable to work in any face-to-face way. In addition to the key roles delegates played over this period, smartphone technology also became a lifeline. New platforms to connect, such as group messenger, WhatsApp, and Zoom, were used constantly. These technologies not only helped surmount the obstacles imposed by the lockdown's social restrictions, but they also opened up communication between NZNO staff and members not practised on this scale before.

Delegates organised ward Q&A sessions on group messenger between fellow members and organisers. Organisers were able to answer questions in real time and promote easy access between members and their union. In addition to connecting with members, NZNO staff stayed connected with each other through the very same technologies. Isolated in our separate homes, we regularly checked and discussed the latest developments across our diverse worksites. Such a sense of connectedness – between members and NZNO staff and among NZNO staff – was crucial in ameliorating the disconnectedness implicit in the lockdown. Let's hopes such connections are maintained in our post-lockdown world. •

Cancer services expecting patient influx

CANCER SERVICES are preparing for an influx of patients after a two-month backlog on screening and diagnoses, as well as cancelled surgeries, chair of the cancer nurses' college Sarah Ellery said.

That was likely to include newly diagnosed patients who had not sought help during lockdown, as well as those whose condition had worsened. "There will be pressure. People have not been going to their GPs for health issues, so yes, definitely there's going to be an impact over the next six weeks in oncology, by the time people move through the service to us."

Ellery said cancer screening, diagnoses and surgeries slowed almost to a halt during alert levels 4 and 3, with only essential, rather than elective, procedures being carried out. But it was left to individual district health boards (DHBs) to decide what was considered "essential", resulting in regional variation.

"In my service, we have 400 fewer referrals [over the four week lockdown period], and diagnostic services and surgery are not happening as usual, so people have not been coming through to oncology for chemotherapy."

Curative surgeries dropped by a third over April, compared to a year ago, while cancer registrations and diagnostic tests were also down, Ellery said, according to a Ministry of Health (MoH) cancer control agency report released late last month. Chemotherapy and radiation were much less affected.

College chair Sarah Ellery

Working groups of cancer clinicians provided advice via the MoH on the range of criteria for priority treatment over the lockdown – whether it would cure or extend life, and how successful it was likely to be. But it took time for these criteria to come through and, with no national directive backing the advice, each DHB was left to make its own decisions, initially.

"Telling cancer patients they couldn't be treated – whether it was with chemotherapy, radiotherapy or surgery – was "distressing" for everyone, she said. "Staff were distressed, as we were having to consider rationing care, and of course the patients were distressed."

While it was obvious some non-urgent operations, such as hernia repair, could be delayed, it was less clear for cancer surgeries. She knew of one patient with recurrent breast cancer who needed surgery, but was initially turned away in the private sector.

"Potentially services wound down so much at the start of level 4, there needed to be some communications [from MoH] on winding them up," she said. "I think once we got further into level 4, and the numbers weren't growing within DHBs, decisions were made to increase the patient flow. But those decisions were being made at a service level."

She believed the MoH could "take more of a lead" in a pandemic situation like this. "It may not be the last time in our lifetimes." •

College responds to NZNO's draft strategic plan

THE CANCER nurses college has told NZNO its board and management need to be more "open to critical feedback" and members' voices, in its feedback on the draft strategic plan.

"Rather than publishing defensive position statements, they should be publishing statements encouraging member feedback regarding their concerns. From current activities, NZNO could be viewed as holding the importance of public image and professional standing over and above staff wellbeing and free speech."

College chair Sarah Ellery told *Kai Tiaki Nursing New Zealand* the plan provided a "much-needed overarching strategy" for NZNO. "However, given the events over the past year or two, it is clear the senior management and board have a great deal of work to do to become functional and implement this strategy."

She said nurses did not feel NZNO was truly a member-driven organisation, despite rising membership fees. "In return, there is a high level of dysfunction which is impeding the organisation from addressing issues for nurses in a highly effective way."

Greater transparency over NZNO spending was also sought. "It is questionable if the recent SGMs and legal fees incurred have benefitted the members or their interests," the college feedback stated. The college also said "significant work" was needed to achieve its draft strategy aims of equity across pay, education, access to clinical and cultural supervision, and safe staffing.

The college also wanted greater use of electronic voting to allow members to express their issues directly, rather than via a "cumbersome" and outdated delegate system.

The college said individual nurse's voices needed to be heard and represented.

NZNO chief executive Memo Musa said the board would be considering the draft strategic plan, feedback and revisions at its meeting this month.

The 2021-2015 draft strategic plan focuses on three "pillars": a skilled, strong workforce; influencing improved health outcomes; and being an effective and sustainable organisation. Each pillar needed four "dimensions" to succeed: being membership-driven, effective communication, equity and effective leadership. •

System could have continued with surgery

FRUSTRATED PERIOPERATIVE nurses have spent the last two months postponing "hundreds" of surgeries, many of which could have been carried out under lockdown, chair of NZNO's perioperative nurses college (PNC) Juliet Asbery says.

"It's not just about the backlog we're facing now, it's about the patients," Asbery told *Kai Tiaki Nursing New Zealand*.

Under level-4 lockdown, all elective surgery was cancelled for four weeks and longer. Yet, there was capacity and willingness at private hospitals, if not public, to operate on those patients with cancers and painful or disabling conditions – particularly as it emerged that New Zealand was not being overwhelmed by COVID-19, Asbery said.

In an open letter to the Minister of Health David Clark and Director-General of Health Ashley Bloomfield, she said those patients should have received care, when it became evident the system was not overwhelmed and had capacity.

"All these patients would have met criteria for treatment during normal time," she wrote. According to the national ethics advisory committee (NEAC) 2007 pandemic guidelines Getting Through Together, if a patient meets these criteria and the system is not overwhelmed, then they should receive care.

While there had been "attempts" to take up the offer from private hospitals, it was "slow and not expedited at DHB levels". Further action was needed, she said.

A Ministry of Health (MoH) memo to all district health boards (DHBs) on April 21, setting out expectations they deliver more planned care such as elective surgeries, "addressed this to a small extent". But it had come very late and further action was needed. "I think the ministry did the best they could in an emergency situation – however, we would be negligent not to take the opportunity to make improvements to our processes."

Perioperative nurses were concerned elective cases would build up to an "unmanageable level with patients experiencing unprecedented waiting times", she said. Patients also stayed away from GPs during the lockdown. *"As the dust settles, these patients with their skin cancers, hip pain, circulatory issues will return and be added to our already overloaded waiting lists,"* her letter said.

The letter also called for *"collective, national guidelines"*.

"Throughout the COVID-19 pandemic response, each DHB has issued different advice and guidelines to staff relating to PPE [personal protective equipment], the criteria for essential surgery, triage processes and management of COVID patients," she wrote. *"Collaboration is needed between DHBs, the MoH and professional bodies in order to provide clarity and one clear message to perioperative teams.*

"The PNC and perioperative nurses are ready and able to respond to the needs of the New Zealand public to deliver safe surgery. The concerns raised in the letter have the potential to cause significant harm to the New Zealand public, especially in terms of delayed care and treatment. As nurses, we continue to provide care based on evidence, and as compassionate nurses. Clear, consistent messages on guidelines and practice from one central source during times of crisis are vital."

Asbery also sent the letter to the Nursing Council, Health and Disability Commissioner, the NEAC, Worksafe New Zealand and NZNO chief executive Memo Musa. •

Supporting enrolled nurses into practice

FROM THIS month, we are celebrating the inclusion of enrolled nurses (ENs) in the advanced choice of employment (ACE) programme for new graduates. (See also p34.)

The section has been lobbying since 2014 for the inclusion of ENs on both ACE and the supported-into-practice programme for enrolled nurses (EN SIPP). The section compiled the EN SIPP in 2014, and committee members, past and present, have lobbied hard to get funding and recognition for newly trained ENs.

The committee's lobbying over the past six years has finally become a reality and we hope to see more EN positions advertised throughout the country. Advertising of EN positions has already been on the rise since late 2018, when the safer staffing accord was signed between the Ministry of Health (MoH), district health boards and NZNO.

Chief nursing officer Margareth Broodkoorn advised our section committee in November that the new programme would be called EN SIPP. We were thrilled at this acknowledgement of our work, as this was the title we chose in 2014, so it was not confused with the registered nurse-entry-to-practice new graduate programme.

Meanwhile, we plan to meet the Nursing Council and MoH nursing advisers in the near future to discuss expanding the EN scope of practice. This follows our 2019 EN survey, the results of which are currently being assessed. We would prefer to work "in collaboration with" a registered nurse or nurse practitioner, rather than "under the direction and delegation of" as is currently described in our scope. (See also p23.)

But we would welcome any expansion, and look forward to continued dialogue.

Several ENs have already begun studying to become qualified vaccinators, and the Immunisation Advisory Centre is letting employers know that ENs can become authorised vaccinators.

Our 42nd section conference, planned for May, has been postponed until next May in Dunedin.

We are looking for two new committee members, and would love to see younger ENs join the section. They are the future and can make a real difference to our profession. •

Report by enrolled nurses section chair, Robyn Hewlett

Classified advertising

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2020 Nominations to the Nursing Council of New Zealand

Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand
PŌTI / VOTE 20

Nominations are now being called for three nurse members on the Council's board, to be elected by the nursing profession. Elected members will serve for a period of three years.

Any nurse registered by the Nursing Council of New Zealand, as at 5:00 pm Tuesday 30 June 2020 with a current annual practising certificate and a New Zealand residential address may be nominated.

If you are considering standing as a candidate you are strongly encouraged to read all the nomination material, which is available at www.electionz.com/NC2020resource.

Warwick Lampp of electionz.com Ltd has been appointed as Deputy Returning Officer. This means that much of the election information will be sent to registered Nursing Council members by electionz.com via email, including calling for nominations and sending out voting details in due course.

The key election dates are:

Nominations open	Wednesday 27 May 2020
Nominations close	5:00pm, Tuesday 30 June 2020
Voting opens	Monday 27 July 2020
Voting closes	5:00pm, Friday 4 September 2020

Nominations will be called for on 27 May by sending an email to all registered Nursing Council members, a notice on the Nursing Council website and in the June Kai Tiaki (being sent on 15 June 2020). Nominations must be received by the Returning Officer by 5:00pm on Tuesday 30 June 2020.

The completed nomination declaration, biographical sketch, statement of voters, photo and duty to disclose form should be scanned and emailed to the Deputy Returning Officer at nominations@electionz.com before the close of nominations at 5:00pm on Tuesday 30 June 2020.

Nominations received after this time will not be accepted.

If you require any further information, please call the free phone election helpline on 0800 666 045.

Warwick Lampp
Deputy Returning Officer – Nursing Council of New Zealand
3/3 Pukaki Road, PO Box 3138, Christchurch 8140
iro@electionz.com, 0800 666 045

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